ABSTRACT

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AN ANALYSIS OF PRECIPITATING FACTORS AMONG HOMELESS AFRICAN-AMERICAN VETERANS

Advisor: Richard Lyle, Ph.D.

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This study examines some of the precipitating factors among homeless African-American veterans. One hundred twelve (112) survey participants were selected for the study utilizing non-probability convenience sampling. The survey participants were composed of consumers who sought services during the quarterly homeless service day sponsored by the Atlanta VAMC Healthcare for Homeless Veterans Program. The survey questionnaire consisted of 36 items that solicited demographic data, a military profile, psychosocial data, a homeless profile, family of origin, family/social support and individual resiliency data, that was utilized on a four point continuum Likert scale. As a result of bivariate analysis utilizing MRA, the findings indicated that homelessness among African-American veterans in this study does not appear to have a statistically significant relationship to unstable childhood, a supportive family or individual

resiliency. However, the data indicated that significant, although minimal relationships do exist between the independent variables family/social support and family of origin and individual resiliency and family/social support.

AN ANALYSIS OF PRECIPITATING FACTORS AMONG HOMELESS AFRICAN-AMERICAN VETERANS

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TABLE OF CONTENTS

PAGE

ACKNOWLEDGEMENTS..... ii

LIST OF TABLES..... v

CHAPTER

I. INTRODUCTION..... 1

Statement of the Problem 7
Purpose of the Study..... 10
Research Questions 10
Hypotheses..... 11
Significance of the Study..... 11

II. REVIEW OF LITERATURE..... 17

Overview of Homelessness in America..... 17
The Stewart B. McKinney Act..... 19
Ethnicity, Gender, Age, and Homelessness..... 22
Mental Illness, Substance Abuse, and Homelessness..... 25
Veterans and Homelessness..... 29
Family of Origin and Homelessness..... 34
Informal Social/Family Support and Homelessness..... 43
Individual Resiliency and Homelessness..... 52
Theoretical Framework..... 60

III. METHODOLOGY..... 75

Research Design..... 75
Description of the Site..... 76
Sample and Population..... 77
Instrumentation..... 78
Treatment of the Data..... 81
Limitations of the Study..... 82

TABLE OF CONTENTS Continued

CHAPTER

IV. PRESENTATION OF THE FINDINGS..... 84

Demographic Data..... 84
Psychosocial and Financial Support Among Military Veterans... 91
Precipitating Factors of Homelessness..... 93
Research Questions and Hypotheses..... 95

V. CONCLUSIONS AND RECOMMENDATIONS..... 101

Implications..... 112
Recommendations..... 115

APPENDIX A: SURVEY QUESTIONNAIRE..... 116

APPENDIX B: SPSS PROGRAM ANALYSIS..... 121

APPENDIX C: EMORY UNIVERSITY IRB APPROVAL LETTER... 131

APPENDIX D: DVA R&D COMMITTEE APPROVAL LETTER..... 133

APPENDIX E: CLARK ATLANTA UNIVERSITY IRB APPROVAL LETTER..... 135

BIBLIOGRAPHY..... 137

LIST OF TABLES

TABLE

1. Demographic Profile of Study Respondents 85

2. Military Profile of Study Respondents 87

3. Homelessness Profile of Study Respondents 90

4. Psychosocial Profile of Study Respondents 91

5. Financial Support Profile of Study Respondents 92

6. Homelessness Indicators for Family of Origin among Military Veterans.. 93

7. Homelessness Indicators for Family and Social Support among Military Veterans..... 94

8. Homelessness Indicators for Individual Resilience among Military Veterans 95

9. Multiple Regression Analysis Pearson Correlations..... 98

10. Multiple Regression Analysis Model Summary 99

11. Multiple Regression ANOVA 99

CHAPTER I

INTRODUCTION

When President Lyndon Johnson declared a "war on poverty" in 1964, the homeless did not appear in the nation's vocabulary, except perhaps as "bums" or "hobos." The visibility of homeless people increased in the late 1960s and early 1970s, when nearly a half-million hospital beds were closed nationwide in state-run mental hospitals, and their occupants were shipped for community care to neighborhood-based institutions. Unfortunately, a great many of the evicted wound up without shelter on city and suburban streets (Marciniak, 2001).

Ever since that de-institutionalization, the number of homeless (both the mentally ill and others) has continued to increase. Approximately two million persons are now homeless at some time during the year, according to the National Law Center on Homelessness and Poverty (1999). The U.S. Department of Housing and Urban Development has provided more than $1 billion yearly to fund programs for them (Marciniak, 2001).

Homelessness may be on the increase. Corroborating such an opinion are two comprehensive surveys released in December 1999 by the U.S. Conference of Mayors and the U.S. Department of Housing and Urban Development. The Conference of Mayors, for example, reported that most of the cities surveyed had reported more

requests for emergency shelter, which has grown in demand every year since 1985 and leaped 11% in 1998 (Marciniak, 2001; Morse et al., 1999).

In many cases, homelessness signals deeper problems. Persons who qualify as homeless, many times need more than just housing. Their basic need may not be housing at all.

Paradoxically, current public policy at the city and state levels actually generates homelessness. For example, 16% of the nation's mentally ill are likely to be imprisoned, according to a U.S. Department of Justice study released in 1999. Only a minority of those imprisoned are given treatment. Furthermore, upon release, they are seldom referred to local institutions for medical or mental health treatment. Many become homeless, deteriorate, are re-arrested and then return to jail. Unless this predicament changes dramatically, no decline in the number of shelterless can be expected (Marciniak, 2001).

"We have done a terrible job in this country since we de-institutionalized [the mentally ill] in the 70's," says Dean Wright, a homeless expert at Drake University in Des Moines, Iowa. "We just did not provide care to the people that needed care, whether it be medical care, mental health, or substance abuse treatment; and without it, people end up right back in prison or out on the streets" (Marks, 2000, pg. 1).

Homelessness is a very complex and challenging social problem that has not enjoyed widespread popularity as a topic of interest among social scientists and policy analysts. Included among the reasons for this limited concern is the continuing debate

about how to define homelessness and which enumeration methodology best ensures an accurate count and description of the affected population (Dail, 2000).

In the early 1980s, as homelessness increased dramatically across the country, the response was primarily local, until 1983 when Congress responded to testimony that homelessness was becoming a serious problem nationally. As a result, the McKinney Act was established (Foscarinis, 1996).

The Stewart B. McKinney Homeless Assistance Act was the first major federal legislative response to homelessness and, to date, it has been the only one. Enacted on July 22, 1987, the McKinney Act marked the federal government's recognition that homelessness is a national problem requiring a federal response. This act defines a homeless person as one having no nocturnal, permanent, regular and adequate residence; a person having nocturnal residence which includes a public or private shelter, supervised or operated as a temporary residence, an institution that provides temporary residence for individuals, a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings (Foscarinis, 1996).

The term "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an act of congress or state law. This definition primarily targets the literal homeless and those in urban areas; it is legitimately questionable when considering rural homelessness, which tends to be characterized by overcrowding due to doubling up with other family members or living in substandard housing because nothing else is available in the rural community (Dail, 2000).

According to Marks (2000) many believe it is time for a new approach to address the root causes of the problem. Reports estimated that on any given night in America, anywhere from 700,000 to 2 million people are homeless. The National Alliance to End Homelessness (NAEH) developed a plan to cut those numbers dramatically over 10 years. Their plan is a combination of creating more affordable housing and rebuilding mainstream social-service programs to include the transitional programs, comprehensive discharge planning, halfway houses and permanent affordable housing for the mentally ill.

From the NAEH's perspective, the emergency shelter system has become an expensive, national halfway house that is not properly equipped to provide the training, treatment, or transition services people need to put their lives back together. That has helped create a core population of chronically homeless (Marks, 2000).

As the issues of homelessness are addressed, the sub-population of the homeless that continues to exhibit large numbers is the veterans of the United States Armed Forces, of which about one-third is a part of the adult homeless population (World Almanac, 2001). The late Jessie Brown, the former Secretary of Veteran Affairs, stated that homelessness among veterans is "the shame of the nation."

On any given day, it is estimated as many as 250,000 veterans (male and female) are living on the streets or in shelters, and perhaps, twice as many experience homelessness, at some point, during the course of a year (Rosenheck & Koegel, 1993). Many other veterans are considered near homeless or at risk because of poverty, lack of

support from family and friends, and dismal living conditions in cheap hotels or in overcrowded or substandard housing (Lloyd, Cobb, & Dixon, 1995).

The Department of Veteran Affairs (DVA) has been serving homeless veterans for many years through a comprehensive network of health care services and benefits. Although many of these services are not specifically designated for the homeless, they have assisted veterans who were homeless, or prevented them from becoming homeless (Lloyd-Cobb & Dixon, 1995).

Since 1987, the Healthcare for Homeless Veterans (HCHV) program has provided outreach, case management, and residential treatment services to more than 220,000 homeless veterans. These services are provided in 50 states, Puerto Rico and the District of Columbia (Rosenheck, Frisman, & Kasprow, 1999).

The DVA offers a wide array of special programs and initiatives specifically designed to help homeless veterans live as self-sufficiently and independently as possible. In fact, DVA is the only federal agency that provides substantial hands-on assistance directly to homeless persons. Although limited to veterans and their dependents, VA's major homeless specific programs constitute the largest integrated network of homeless treatment and assistance services in the country. Despite the fact that the DVA has implemented more than 100 specialized programs for homeless veterans across the country, homelessness among veterans continues.

According to Rosenheck et al. (1994), veterans appear to be over-represented among homeless men, and this overrepresentation primarily affects younger veterans who served in non-wartime eras, especially the post-Vietnam era. The increased vulnerability

for homelessness among veterans may be related to the admission of poorly adjusted young men to military service during non-wartime eras and to the reduced availability of benefits to these veterans.

Results from this same study that was conducted in 1986/1987, indicated that the proportion of veterans among homeless males is greater than the proportion in the general population. This over-representation is most striking among whites 20 to 34 years old; and to a lesser extent, blacks 20 to 34 years of age. Ages 45 to 54 year-old men of both races are also over-represented (Rosenheck et al., 1994).

Almost all homeless veterans are male (about 3% are women), the vast majority are single, and most come from poor, disadvantaged backgrounds. Homeless veterans tend to be older and more educated than homeless, non-veterans are. But similar to the general population of homeless adult males, about 45% of the homeless veterans suffer from mental illness and (with considerable overlap) slightly more than 70% suffer from alcohol or other drug abuse problems. Roughly 56% are African American or Hispanic (DVA, 2002), which is disproportionate to their percentage of the total population of the U.S.

Perhaps the most distinctive characteristics of veterans in the vulnerable age cohorts is that they served during non-wartime eras, especially during the post-Vietnam era, after establishment of the All Volunteer Force in 1973. The shift to the volunteer force marked an important change in military manpower policy, a change that was accompanied by widespread concern that the military would become an employer of last resort for poorly skilled youth. Studies comparing volunteer force recruits and age

matched civilians show these recruits to have slightly lower socioeconomic status than their non-veteran peers, as well as poorer intellectual aptitude test results and greater problems with substance abuse (Rosenheck et al., 1994).

Statement of the Problem

Rosenheck et al. (1996) report that virtually every scholar who has considered risk factors for homelessness has observed that blacks are over represented among the homeless. Veterans are no exception. Although the problems affecting the general homeless population are numerous, veterans of color experience double jeopardy. In addition to the problems facing the general homeless population, they must contend with issues of prejudice and racial discrimination. Possibly, because of racism in the United States, homelessness is disproportionately higher for African Americans and Hispanics than for white Americans (First et al., 1988).

Whaley (2002) conducted a study comparing demographic and clinical characteristics of African Americans with and without an immediate history of homelessness upon entry into a state psychiatric hospital. Risk groups were based on the accumulation of variables identified from multivariate analysis as significant predictors of homelessness prior to hospitalization. As a result, four variables made statistically significant contributions to the logistic regression analysis model predicting homelessness with the other variables controlled: never being married, life-time co-morbid substance abuse, severe paranoia and high self esteem.

In Whaley's discussion, he made reference to the issue of individual risk factors and homelessness, which according to Schwartz and Carpenter (1999) in most cases, represent superficial causes of homelessness. Homelessness is strongly related to structural factors like employment opportunities and the availability of low-cost housing (Elliot & Krivo, 1991). African Americans tend to be disproportionately affected by structural inequalities. Thus ethnic or racial status may be a proxy for economic vulnerability to homelessness (Whaley, 2002).

Housing discrimination continues to mark the housing choices for both poor and middle income African Americans. In a tight housing market, such discrimination guarantees that African Americans will have few positive choices and a disadvantage in competing for what limited affordable housing is available. African Americans as a group are still locked in segregated neighborhoods within urban areas, and increasingly in suburban areas, even while some cities and suburban areas have managed to overcome these barriers to integration (Massey & Denton, 1988, as cited in Wright, 2002). These are just a few of the studies that support First et al.'s claim regarding racial discrimination and homelessness (First et al., 1988).

A review of the numerous studies addressing homelessness show that studies that focus on homeless African-American veterans are rare. There has been little investigation of unique service needs of the minority homeless population, and research on service use among non-homeless minorities has produced conflicting results, according to Wenzel and Bakhtiar (1995).

A substantial literature has demonstrated that racial discrimination in housing and employment has resulted in especially high concentrations of poverty and other social ills in black neighborhoods in U.S. cities. Such circumstances could make recovery from homelessness especially difficult in the absence of a period of rehabilitation in a safe, substance free, supportive environment (Rosenheck et al., 1997). Following is a case and point.

Virgo et al. (1999) reports that among veterans treated at a VA substance abuse triage unit, predictors of repeated usage were African-American race; male gender; and among alcoholics, homelessness. A recent analysis of inpatient readmission rates for substance users showed that veterans treated in community-based residential programs had lower one and two year readmission rates than patients who received hospital based residential care. Longer episodes of residential care and more frequent outpatient mental health visits were also associated with lower readmission rates. These findings may be an indication of a deeper issue in regards to how homeless African-American veterans' treatment needs are being assessed and addressed by clinicians and others.

However, in reference to military experiences and homelessness, scientific studies indicate that there is no known, direct connection between military service, service in Vietnam, or exposure to combat and any increased risk of becoming homeless. Family background, access to support from family and friends, and various personal characteristics (rather than military service) seem to be the stronger indicators of risk of homelessness (Rosenheck & Koegel, 1993).

Purpose of the Study

The purpose of this study is to analyze precipitating factors among homeless African-American veterans. The primary focus of the study is to explore secondary factors associated with homelessness among this population of veterans. Specific family of origin factors as well as social support and family preservation factors and factors pertaining to the veterans' individual resilience and problem solving abilities was investigated to determine how they might influence the social phenomena of homelessness among African-American veterans, including the duration and the number of episodes of their homeless experiences.

Research Questions

The research questions of this study are as follows:

1. Is there a relationship between an unstable childhood and homelessness of African-American military veterans?
2. Is there a relationship between supportive family and homelessness of African-American military veterans?
3. Is there a relationship between individual resiliency and homelessness of African-American military veterans?

Hypotheses

The null hypotheses for this study are as follows:

1. There is no statistical significant relationship between an unstable childhood and homelessness of African-American military veterans.
2. There is no statistical significant relationship between a supportive family and homelessness among African-American military veterans.
3. There is no statistical significant relationship between individual resiliency and homelessness of African-American military veterans.

The following dependent and independent variables were utilized while addressing the issues of homelessness:

Dependent Variable – homelessness among African-American veterans.

Independent Variables – family of origin factors, social/family support, and individual resiliency.

Significance of the Study

The homeless population exhibits a wide variety of characteristics. Some homeless people have mental illnesses or substance abuse illnesses, whereas others are handicapped. Some have a criminal justice history; others are escaping from violent domestic situations. Most are men, and minorities tend to be over-represented in the population. It is important to emphasize that, although these are some of the

characteristics of homeless people, they may not be the causes of each individual's homelessness. The causes may be found in an interrelated set of socioeconomic factors that have become prominent over the past two decades. These factors include lack of affordable housing, decreasing incomes for poor families, changing health care issues and treatment availability, and the increasing instability of families (Roman & Wolfe, 1997).

According to Roman and Wolfe (1997), the public sector's failure to address the increasingly important roles that drugs, disabilities, and chronic health problems play in the lives of poor people has also contributed to a greater vulnerability to homelessness. While the incidences of alcoholism, substance abuse illnesses, and other illnesses (HIV, AIDS, and tuberculosis) are on the rise, treatment has in many cases become less available or prohibitively expensive (Roman & Wolfe, 1997).

The problems experienced by homeless individuals are as varied as the causes of homelessness. Among the major problems experienced by homeless individuals are severe mental and physical illness, alcohol and other substance abuse, chronic unemployment, and menial jobs and wages (Robertson, 1987; Rosenheck & Koegel, 1993). Negative public attitudes and reactions to homelessness such as laws aimed at curbing panhandling, public nuisance, loitering, and sleeping in public places have also been cited as problems (National Law Center on Homelessness and Poverty, 1993).

Additionally, homelessness has a profound effect on families both directly and indirectly. Studies have found that domestic violence is a leading cause of homelessness for women. Zorza (1991) found that 50% of the women in her study were victims of domestic abuse. Dail, Shelley, Fitzgerald, and Baker (1997), in a statewide study of

homelessness in a rural state, also found domestic abuse and family disruption to be the primary cause of homelessness among all homeless, 55% of whom were children (Dail, 2000).

Problems affecting homeless veterans include physical, addictive, and post-military psychiatric disorders; social isolation; social and vocational dysfunction; mental health and community adjustment problems; war and non-war-related traumatic experiences; and low self esteem (Rosenheck et al., 1991; Suber et al., 1988; Winkleby & Fleshin, 1993). The diverse problems facing the homeless veteran population represent a growing concern to health and human services practitioners faced with the difficult task of delivering services to this highly vulnerable group (Applewhite, 1997).

A large portion of the homeless veterans' population is Vietnam era veterans, who alone, present with a variety of complex problems, including post traumatic stress disorder (PTSD). When large numbers of veterans were observed among the homeless, researchers emphasized that their presence was probably yet another manifestation of the Vietnam War, whose legacy tragically extended across the decades to the present (Rosenheck, 1994).

Several studies have focused on veterans, a group that may differ significantly from the general homeless population. These veterans, frequently Vietnam combat veterans, suffer from serious mental illnesses (e.g., post-traumatic stress disorder {PTSD}, schizophrenia and affective disorders, and substance abuse disorders). Homeless veterans with mental disorders appear to be high users of expensive psychiatric services, such as inpatient and emergency treatment (Stovall & Flaherty, 1997).

One such study was conducted by Rosenheck and Fontana (1994). This study explored a multi-factorial model of vulnerability to homelessness among male veterans of the Vietnam war generation. Data from 1,460 male veterans who participated in the National Vietnam Veterans Readjustment Study were used to evaluate hypotheses about the causes of homelessness grouped into four sets of sequential variables: 1) pre-military risk factors, 2) war related and non-war related traumatic experiences, 3) lack of social support at the time of discharge from military service, and 4) post-military psychiatric disorder and social dysfunction. Post-military social isolation, psychiatric disorder, and substance abuse had the strongest direct effects on homelessness, although substantial indirect effects from stressors related to being in the war zone and from pre-military conduct disorder were observed.

Several pre-military factors such as year of birth, childhood physical or sexual abuse, other childhood traumas, and placement in foster care during childhood, also had direct effects on homelessness. In view of this complex pattern of influences, prevention efforts directed at individuals must address a very broad range of adjustment problems (Rosenheck & Fontana, 1994).

Research shows that veterans who suffer from PTSD are likely to engage in family violence and that increased violent behavior characterizes their children. So failure to care for veterans and their families [may be] a contributing factor for youth violence (Allen, 2000). Including military histories in health assessments would help identify risk factors to consider in family interventions.

Failure to address the issue may result in the possible continuation of the cycles of homelessness as well as the failure by the public health community to eradicate homelessness. In essence, community agency staff and other homeless advocates may continue to be baffled and at a loss regarding how to effectively accommodate and assist homeless veterans and their families if adequate attention is not given to this population. Homelessness damages the physical and mental health of those who are homeless and poses risks for the non-homeless population by contributing to the spread of diseases such as tuberculosis and AIDS (Phelan & Link, 1999).

Bollard and McCallum (2002) assert that recent studies by Link and his colleagues demonstrate that the prevalence of homelessness in the United States is far greater than had been previously imagined. In addition to direct effects on homeless people themselves, however, homelessness may indirectly affect the lives of many others, particularly the people who provide respite from the streets for those who are literally homeless. Thus it is of critical public health importance to understand what causes homelessness, how it can be prevented, and how episodes of homelessness can be curtailed, particularly in the African-American veteran community.

Second, this study may have implications regarding policy formulation for homeless veterans who, not only, are presently experiencing problems with homelessness but have had multiple bouts of homelessness over an extended period of time. According to Rosenheck (1994), homelessness is a serious public health issue in its own right. In addition, homeless people suffer from associated conditions such as mental illness, alcoholism, tuberculosis, and a substantial excess of deaths.

Link et al. (1994) indicate that homelessness is not an isolated problem that can be resolved through emergency interventions with currently homeless persons. It is a symptom of much deeper and more serious changes in American society. How these changes can be reversed is not easy to specify in policy recommendations that are both empirically based and politically acceptable.

Effective action is urgently needed in the areas of housing, health care, employment, and education. The alternative of continued social disintegration will have great consequences for the national health and welfare and makes this a problem which can not be ignored. Only with policies aimed at providing the means and specialized programs necessary to attack this public health problem and its symptoms will the issue of homelessness among veterans, [specifically African-American veterans], be adequately addressed (Link et al., 1999).

CHAPTER II

REVIEW OF LITERATURE

This chapter provides a discussion regarding various issues about homelessness in America and the overall general homeless population, including addressing homelessness from a historical perspective. It also reviews the literature pertaining to the specific variables and other pertinent information that may offer an explanation to assist with understanding and addressing this very important public health problem.

Overview of Homelessness in America

America has always had poor people, but they were not always homeless. In colonial times, a two-track system developed through which indigent people could get food and shelter if personal and family resources failed. For destitute individuals deemed "worthy" of community support, shelter was provided in private homes and public institutions. For example, in 1734, New York City established an almshouse for widows, orphans, and people with physical disabilities. "Unworthy" individuals, such as fugitive slaves, alcoholics, and men without permanent residences, came under the jurisdiction of penal institutions (Bruckner, 2001).

Homelessness became widespread when the Civil war led to the displacement of thousands of civilians and veterans. At the end of the war, many veterans went west seeking work and adventure. Some of the veterans became outlaws, and some of them became hoboes, leading to a public perception that homeless people had suspicious backgrounds with criminal leanings. Many of these homeless veterans had amputations or other war-related injuries, reinforcing the association between physical disability and homelessness (Bruckner, 2001).

Toward the end of the 19th century, industrialization, economic expansion, and modernization demanded a mobile, unskilled workforce. The neighborhood became synonymous with abject poverty, single-occupancy rooms, cheap restaurants, missions, bars, and brothels. In 1873, commercial failures resulted in a national unemployment rate of 30% to 40%, and skid row neighborhoods were predominantly young (between 20 and 40 years of age), male, American-born, and the products of unstable, abusive families (Bruckner, 2001).

By 1910, an estimated 3 million hoboes traveled across America in search of work. Hard times continued, and by the Great Depression of the 1930s, nearly a third of the labor force was unemployed. Farms failed and whole families became homeless. Government programs tried to provide relief for the 1.5 million homeless Americans. The almshouses that once gave respite to the "worthy" poor now served older adults (Bruckner, 2001).

During World War II, the military enlisted able-bodied men, so only the old and infirm remained on the streets. Skid row districts became repositories for destitute, old

men. Ethnographies of these skid row "bums" show that they came from dysfunctional families, had little formal education, were very poor, were alcoholic, had numerous health problems, and had repeated arrests for intoxication and other crimes (Bruckner, 2001).

The Stewart B. McKinney Act

Little changed over the years until the 1980s, when public interest in the homeless grew. Media coverage, publications, and advocacy efforts spotlighted the conditions of homeless Americans and led to the passage of a number of entitlement programs, including the Stewart B. McKinney Act of 1987 (Bruckner, 2001).

Homelessness has now been on the American policy agenda for two decades. In 1989, when the Urban Institute published *America's Homeless* (Burt & Cohen, 1989), policymakers and the public may have expected, or hoped, that we could end the crisis of homelessness relatively quickly. The decade of the 1990s has not fulfilled that expectation. Programs and services to help homeless people expanded dramatically in the 1990s, just as they did in the 1980s. At the same time, visible homelessness in many American communities does not seem to have diminished. How are we to think about the persistence of homelessness at the end of a decade of unprecedented prosperity, and at the dawn of a new millennium (Burt et al., 2001)?

Because it is a public health issue as well as a social problem, homelessness is a complex matter; therefore, this is a complicated question that cannot be answered in

simple terms. Given that homelessness stems, at base, from an inability to afford housing, the structural conditions of the economy, housing markets, labor markets, and related factors that influence people's ability to afford housing, must be considered. People's individual characteristics as well as ways in which the United States has chosen to address homelessness from the federal level must be examined also (Burt et al., 2001).

In addressing the myriad of questions that are proposed as a result of discussing homelessness, it is appropriate to initially discuss how politicians have responded to this public health issue. Briefly and from a historical perspective, attempts to alleviate homelessness on the federal level can best be described via the following legislation, the Stewart B. McKinney Act.

The Stewart B. McKinney Homeless Act (PL100-77) was the first and remains the only major federal legislative response to homelessness. The McKinney Act originally consisted of fifteen programs providing a range of services to homeless people, including emergency shelter, transitional housing, job training, primary health care, education, and some permanent housing. It contained nine titles. It has been amended four times: in 1988. 1990, 1992 and 1994. These amendments have, for the most part, expanded the scope and strengthened the provisions of the original legislation. Since the passage of the McKinney Act in 1987, the McKinney Act programs have been expanded, and funding has significantly increased. However, McKinney programs now face new challenges as homelessness persists unabated across the country (National Coalition for the Homeless, 1999).

The McKinney Act has created valuable programs that have saved lives and helped hundreds of thousands of Americans to regain stability. However, evaluations of the program have found that the resources allocated to the McKinney programs are insufficient to meet demand, and that lack of adequate funding limits the programs' success. While inadequate funding clearly impedes the effectiveness of the McKinney Act programs, the McKinney Act's greatest weakness is its focus on emergency measures. It responds to the symptoms of homelessness, not its causes (National Coalition for the Homeless, 1999).

The McKinney Act was intended as a first step toward resolving homelessness; in the absence of legislation containing farther reaching measures, homelessness can only be expected to increase. It was and remains, landmark legislation. The programs created by the McKinney Act are needed now more than ever, as homelessness shows no signs of abating. However, after more than a decade of an emergency response to a long-term crisis, it is clear that only by addressing the causes of homelessness, lack of jobs that pay a living wage, inadequate benefits for those who cannot work, lack of affordable housing, and lack of access to health care, will homelessness be ended (National Coalition for the Homeless, 1999).

Who are the nearly 4 million men, women, and children now homeless in America? According to both the National Law Center and the National Coalition for the Homeless, people who have jobs make up 1,300,000, children under 18 make up 1,000,000 and people ages 31 to 50 make up 2,040,000 (Literary Cavalcade, 1999).

Homelessness remains one of the most misunderstood and least documented social policy issues of our time. For almost two decades, the majority of efforts to understand the issues surrounding homelessness have focused solely on transient men. Yet over the last fifteen years, the country has seen the rise of a new poverty: homeless families. Each year since 1993, the U.S. Conference of Mayors has reported that this group comprises the fastest growing segment of the homeless population. (Nunex & Fox, 1999).

Today, there are 400,000 homeless families in shelters representing 1.1 million homeless children across America. Many Americans refuse to believe, however, that entire families are homeless in the richest country of the world. This collective denial has had grave consequences for homeless children and their families. The lack of hard data has not only obscured the complex nature of family homelessness, it has led to a crisis of policy in the dark. Policy prescriptions that are politically expedient have dominated public discourse. However, these policies are long on rhetoric and short on a reasoned appreciation for the myriad factors that contribute to and sustain family homelessness (Nunez & Fox, 1999).

Ethnicity, Gender, Age, and Homelessness

Like the total U.S. population, the ethic makeup of homeless populations varies according to geographic location. For example, homeless people in rural areas are more likely to be white. Homelessness among Native Americans and migrant workers also

tends to be in rural areas (U.S. Department of Agriculture, 1996).

Although research also suggests that culture is one of the variables that significantly affects the construction and meaning of any social phenomenon, few studies have been devoted to homelessness, a particularly powerful social phenomenon, among ethnic groups (First, Roth, & Arewa, 1988).

Until this current wave of homelessness, the homeless were identified as a predominantly white population. Yet the homeless today, identified through street surveys and shelter caseload statistics, include a greater share of ethnic and racial minorities than we see in the general population. But this simple statement obscures a more interesting paradox. Whereas African Americans are over-represented in nearly all studies of homelessness, Latinos tend to be under-represented and it is most apparent among the males (Baker, 1994). According to studies conducted by Link et al. (1994), people who were young, single, male, and African-American were over-represented among the population of currently homeless people.

According to Baker (1994), demographic diversity among the homeless consists of two key dimensions, gender and ethnicity. Recent research has uncovered interesting contrasts in both the incidence of homelessness and the nature of the homeless experience for men and women, and for whites and non-whites.

Baker (1994) reported that local case studies suggest that homelessness may be a more episodic experience for racial and ethnic minorities than it is for non-Hispanic whites. Both African Americans and Latinos seem to experience more frequent spells of homelessness for shorter durations than do non-Hispanic whites (Rossi et al., 1987).

Rossi (1988) noted that a time gap exists for all homeless people between their last steady and the onset of their current homelessness spell. For Latinos and African Americans, this time gap is longer than it is for non-Hispanic whites, implying that they may avoid homelessness far longer on inadequate incomes. But once homeless, both minority groups are more likely than non-Hispanic whites to slip into numerous episodes of homelessness.

Homeless women are younger, on average, than homeless men. This is particularly true of homeless women with children. Burt (1992) found homeless women with children to be 9 years younger, on average, than their single male counterparts (30 years vs. 39 years old), whereas fully 20% of the single women in the Burt sample were under 25 years of age.

Furthermore, age structure is the key demographic feature distinguishing ethnic groups among the homeless. Both African-American and Latino homeless subgroups tend to be younger than their white counterparts. Both subgroups are most likely to include a majority of men and women in the prime ages of labor force activity (Baker, 1994).

Other factors in addition to gender, ethnicity and age define the homeless population and provide information about other variables that affect homelessness. Not only are the correlates of street life different for men and women but the duration of the homeless experience differs as well. Burt's (1992) data indicated that homeless women report shorter spells of homelessness than do men. For example, the average

length of current homelessness was 41 months for single women. Thus, homeless women with children appear to have avoided homelessness with meager resources far longer than had either single women or single men. The average length of a current jobless spell for women with children by over 2 years versus less than a year for either single men or women. Clearly, the resources available to women with children must somehow differ from those of their single counterparts (Baker, 1994). But this is questionable also.

Mental Illness, Substance Abuse, and Homelessness

According to Anderson and Imle (2001), mental illness is presumed by many to be a factor that leads to homelessness. Studies are equivocal in their findings, with estimates of mental illness ranging from 9% to 84% in studies of homeless persons (Caton et al., 2000).

In her discussion of gender and ethnicity, Baker (1994) further addresses the physical and mental health status of the homeless. Although much has been written about this population, less is known about gender variation in some of the key characteristics of vulnerability that are over-represented among the homeless. Overall, homeless women demonstrate a lower prevalence of treatment for various physical and psychological disorders; however, some interesting variation exists among subgroups of homeless women.

In the nationwide study, Burt (1992) found that single homeless women (who are also older on average, than women with children) demonstrated a nearly 50% higher rate of previous hospitalization for mental illness than did single homeless men (27% vs. 19%), whereas homeless women with children reported a lifetime prevalence rate of mental illness (9%) less than half that of men. Both major female demographic subgroups had lower rates of chemical dependency treatment (11% for women with children, 39% for single women) than was true for men (48% of whom reported such experience).

Despite differing treatment histories, the three dominant gender/family composition groups, single men, single women and women with children, had comparable outcomes on standardized psychiatric tests for depression developed by the Center for Epidemiological Studies for the National Institute of Mental Health. At least as far as self-report data are concerned, homelessness is less closely correlated with evidence of severe personal disability for women, particularly women with children, than is the case for men (Burt, 1992).

It is estimated that only 5% of the 4 million persons with a serious mental illness are homeless at any given time (National Coalition for the Homeless, 1999). Mental illness among homeless women with dependent children, the fastest growing population of homeless, is not common. A lifetime prevalence of abuse may, however, precipitate a woman's mental illness, particularly depression (Dienemann et al., 2000), leading to loss of a job, poverty, and then homelessness.

Mental illness is the personal disability most commonly associated with homelessness. Freeman and Hall (1987) estimate that the mentally ill are 15 times more likely to be homeless than the general population. Little evidence exists to suggest that mental illness rates vary across ethnic groups in magnitudes dramatic enough to produce the observed variation in homelessness. Latino and African-American homeless people do not demonstrate higher levels of mental illness than whites in local case studies. In fact, clinicians in a nationwide network of shelter-based clinics were twice as likely to diagnose psychiatric disorder for non-Hispanic white clients as far as for African-American or Latino clients (National Academy of Sciences, 1988 as cited in Baker, 1994).

Also, substance abuse is the most common mental health disorder not only among the homeless but also in the U.S. population at large. In 1984, American Assembly reported estimates of alcoholism in the U.S. population ranging from 4% to 8%. Homeless case studies identified a much higher rate of heavy alcohol use. One review of numerous studies estimated an average alcoholism prevalence of 47% (National Academy of Sciences, 1988 as cited in Baker, 1994).

Both African Americans and Latinos were over-represented in a 1984 review of the client caseloads of alcohol and drug treatment units, constituting 15% and 9% of alcohol clients and 29% and 16% of drug clients, respectively. But self-report data show alcohol use to be more prevalent among non-Hispanic whites than among Latinos or African Americans and little ethnic variation in overall rates of "illicit drug" use reported (U.S. Department of Health and Human Services, 1989 as cited in Baker, 1994).

These ethnic patterns repeat themselves in homelessness research. Whites are more likely to report both alcohol abuse and detoxification treatment than do either African Americans or Latinos. Other illicit drug use is more common among both minority groups than among non-Hispanic whites (National Academy of Science, 1988).

In sum, alcohol is the most significant substance abuse risk factor among the homeless, and it disproportionately affects non-Hispanic whites. Although some evidence suggests higher rates of other drug abuse among the minority homeless, crack and powder cocaine, for example. These differences actually run counter to the under-representation of Latinos in the population and are unlikely to account for the ethnic patterns that are observed (Baker, 1994).

The Alcoholism and Drug Abuse Weekly (1995) reported that treating persons with addiction and mental disorders has proven itself a formidable task, in a country with an estimated 600,000 persons on the street or in shelters on any given night. Fragmentation of substance abuse and mental health treatment services, along with a lack of cross-training between the disciplines, is a big reason why there is little treatment for the estimated 100,000 homeless persons with a substance abuse disorder and serious mental illness, officials say.

Dr. Richards, director of intergovernmental initiatives for the federal Center for Mental Health Services (CMHS), indicated that this has traditionally been a difficult population to treat and stresses an integrated approach as the only way to effectively treat homeless persons with co-occurring disorders, which can be difficult to identify. Mental health and addiction problems often mask each other. But leaving one illness untreated,

officials say, often hinders efforts to treat the other and can trigger relapse (Alcoholism and Drug Abuse Weekly, 1995). Relapse and mental illness can perpetuate the cycle of homelessness as the previous statistics indicate.

According to the results of the 1996 National Survey of Homeless Assistance Providers and Clients (1999), single men comprise the largest proportion of homeless persons (68%). Eighty-four percent (84%) of homeless families were likely to be headed by women, and 71% of homeless people reside in urban settings. The number of veterans is lower than in other reports (23%).

Veterans and Homelessness

More specific information about the veteran population indicates that approximately 40% of homeless men are veterans, although veterans comprise only 34% of the general adult male population. The National Coalition for Homeless Veterans estimates that on any given night, 271,000 veterans are homeless (National Coalition for Homeless Veterans, 1994).

Homeless veterans are more likely to be white, better educated, and previously or currently married than homeless non-veterans. Female homeless veterans represent an estimated 1.6% of homeless veterans. They are more likely than male homeless veterans to be married and to suffer psychiatric illness, but less likely to be employed and to suffer from addiction to disorders. Comparisons of homeless female veterans and other homeless women have found no differences in rates of mental illness or addictions.

Minorities are over-represented among homeless veterans just as they are among the homeless population in general. However, there is some evidence that veteran status reduces vulnerability to homelessness among black Americans (Rosenheck, 1996).

Contradicting this claim is Higate (2000), who reported that ex-servicemen may be disadvantaged as a consequence of the extra demands created by the "do-it-yourself biography" (Beck & Beck-Gernsheim, 1996). For example, single ex-servicemen who lived on-base may remain dependent on paternalistic military structures, as the institution assumed total responsibility for housing them in barrack blocks (Beevor, 1991; Jessup, 1996); these conditions contrast sharply with the insecure employment and housing markets in civilian life. The starkest indication of the tensions between "institutionalized" ex-servicemen and housing/labor market asymmetries is signaled by this group's apparent propensity to homelessness.

According to Rosenheck et al. (1996), data from prior studies indicated that 47% of homeless men are black, as compared to only 11% of all adult U.S. males. These data suggest as well that the relative risk for homelessness among blacks is 7.3 times that for whites. Additionally, when veterans and non-veterans are compared, black veterans are 1.4 times more likely to be homeless than white veterans. In contrast, black non-veterans are 2.9 times more likely to be homeless than white non-veterans.

Rosenheck et al. (1996) further asserted that the 1987 current population survey data on employment, education, income, and marital status, indicated that a comparison of white post-Vietnam veterans and matched non-veterans revealed few differences and does not suggest an explanation for the strikingly different risk of homelessness among

veterans and non-veterans in this age-race group. Data on black veterans in this age cohort, however, show them to be substantially better off than black non-veterans: they have higher incomes, lower poverty and unemployment rates, and a lower probability of living alone. These data are consistent with the fact that the overrepresentation among the homeless of post-Vietnam black veterans is significantly smaller than the over-representation of their white peers.

Studies from the 1980s consistently reported that homeless veterans were older and more likely to be white than other homeless men. Some studies reported that they had more often been in jail and were more likely to have problems related to alcohol use or to have been hospitalized for psychiatric or substance abuse problems. Additionally, reanalysis of the data from three surveys of this period found that homeless veterans were older than non-veterans, more likely to be white, better educated, and previously or currently married (Rosenheck et al., 1996).

In a study conducted by Applewhite (1997), a focus group of veterans, in an informal setting, was utilized to obtain information regarding what they consider to be the major problems and barriers confronting homeless veterans seeking social services. They revealed three types of problems including health and mental health, resource related and public perception problems. Health and mental health problems reflected a wide range of concerns centered around chronic health problems, substance abuse, psychosocial and clinically diagnosed problems, and self-esteem problems. Substance abuse was viewed as a major obstacle to overcoming homelessness. Addictive behaviors such as alcoholism and drug abuse were separately identified in every focus group discussion,

with many participants describing their experiences with alcohol and drugs and the drug culture that dominates the world of homelessness.

Veterans consistently discussed their efforts to deal with medical and clinical problems such as seizures, depression, schizophrenia, adjustment issues, post-traumatic stress disorder (PTSD), and flashbacks and the compounding effects of those problems on their daily struggle for survival. Most psychosocial and psychiatric problems came from veterans who experienced combat duty while serving in Vietnam. These veterans noted their experiences had a profound impact on their ability to fully adjust in society (Applewhite, 1997).

Higate (2000) proposed a similar hypothesis. It has been recently argued that a disproportionate number of the single homeless population has a background in the armed forces, and that this can be explained by the ex-servicemen's vulnerability to the effects of "military institutionalization." In these popular understandings, the longer-term influence of military socialization is claimed to limit the development of a range of skills vital for re-integration into civilian life (Randall & Brown, 1994; Jolly, 1996 as cited in Higate, 2000).

The problems and needs of homeless veterans are not unlike those affecting the general homeless population and are largely associated with poverty, unemployment, social isolation, substance abuse, and chronic mental illness. To the extent that homeless veterans share similar problems and conditions with other special populations, such as homeless adolescents, homeless elderly people, homeless women with children, and homeless people of color, then all homeless people should be served equitably in the

most efficient manner. Some problems, however are more specific to veterans, such as war-related post-traumatic stress, readjustment problems, and feelings of victimization related to unmet expectations about war service recognition (Applewhite, 1997).

In a study conducted by Rosenheck et al. (1997), comparisons of service use and treatment outcomes for 145 black and 236 white homeless veterans with mental disorders showed few differences. A greater improvement in psychiatric symptoms and alcohol problems among white than black veterans did not hold true when black veterans had participated in the residential treatment component of the program. The findings of the study suggest that blacks have a greater need for residential treatment services to maximize their gains in some areas.

Further studies, however, are needed to confirm and expand on these preliminary findings. More specifically, additional information is needed on differences in the personal experiences of patients of different races in different types of treatment, as well as of the relationship to outcomes of racial matching between client and clinician. Such controversy blunts optimism about effective intervention; however, it cannot excuse scholarly and policy inaction. Rather, a heterogeneous homeless population requires a systematic plan to understand the origins of its demographic diversity. This understanding may help map the many pathways to the street and guide policymakers toward better efforts to redirect the flow down those pathways (Baker, 1994).

Examination of the African-American homeless veteran population provides an excellent place to start. In an effort for planners and service providers to address this public health issue among homeless veterans, it is crucial that the possible causes of this

problem be addressed, specifically in regards to the African-American veteran. Research confirms that the social and economic status of the African-American male has deteriorated over the past quarter century. It is well documented that their rates of school failure, joblessness, homicide, incarceration, and other antisocial behaviors far exceed those of their white, Hispanic, and Asian male counterparts. In fact, the magnitude of these problems has led some researchers to characterize the African-American male as an endangered species (Johnson et al., 2000).

Family of Origin and Homelessness

The following literature review explores the various secondary factors and other pertinent information that may offer an explanation to assist with understanding the origin of this phenomenal problem that has consumed the lives of a large number of African-American military veterans. Theories, hypotheses and the research findings of others who have conducted studies on the subject of family of origin influences and factors , informal social support systems and individual resilience in relation to homelessness is also discussed.

Since colonial times, there has been an association among poverty, physical disability, and homelessness (Bruckner, 2001). Historical information regarding the family of origin is a variable that may provide pertinent information about African-American veterans and their susceptibility to becoming homeless.

Historical information focuses on whether the veterans were raised in a single

versus two-parent traditional family environment and whether adversities, poverty or economic conditions were a factor common to that environment. The latter variable will focus on whether Aid to Families with Dependent Children (AFDC) and Temporary Assistance to Needy Families (TANF) were the financial means utilized to support the needs of the family.

Homelessness is a devastating experience for families. It disrupts virtually every aspect of family life, damaging the physical and emotional health of family members, interfering with children's education and development, and frequently resulting in the separation of family members. Deep poverty and housing instability are especially harmful during the earliest years of childhood (Homes for Homeless, 1998).

According to Roman and Wolfe (1997), the number of single-parent families has increased dramatically in recent years. In 1970, single-parent families accounted for 14% of all families; by 1992 this had risen to 22%. In 1991, female headed households accounted for 39% of the poor population of the nation. Nearly half of all African-American children and over two-fifths of Hispanic children live in such households. As a result of economic and social changes, poor families often experience severe stress. Parental stress often leads to child abuse and neglect, the reports of which have almost tripled since 1980. Family stress can also result in spousal abuse and divorce.

Children who are abused or neglected, whose parents become homeless, or whose families dissolve often become involved in the foster care system. Lack of

housing, low incomes, lack of services, and increasing family instability, along with other factors, have contributed to the instability of individuals and households and, eventually, to their homelessness. (Roman & Wolfe, 1997).

The family of origin has a strong influence on lifelong behavior and plays an important role in one's current life situation (Bretherton, 1995; Goldberg 1997; Sarason, Sarason, & Pierce, 1990 as cited in Anderson & Imle, 2001). Research is now also providing better understanding of the processes that lead to homelessness and the ways in which people get out of it. Significant predictors for homelessness in adult life include events and circumstances as far back as childhood, such as physical abuse, parental absence, residential instability, or placement in foster care. The way a homeless person is treated may affect the likelihood of his/her becoming homeless again 2 years later (Breakney, 1997).

Sleegers and associates reported that all but one of a homeless research sample claimed to have experienced one or more adverse life events, and 56% reported more than four such events. This same study showed that parental divorce, antisocial behavior, and substance abuse can be contributing factors as well as low parental educational level and/or less skilled parental jobs, less likelihood of a father in the home, high birth order in a large family, family conflict and family problems. Foster-care placement (15%), or group home placement (10%) in the past may be a factor: Fifty-eight percent (58%) of homeless adolescents had experienced some kind of out-of-home placement, running away (20%) or early departure from home (Martens, 2002).

Anderson and Imle (2001) indicated that support networks are necessary for optimal development of the strengths and sense of self-worth in children that may prevent disconnectedness and later homelessness. Building and maintaining these relationships begins in the family of origin and continues for a lifetime.

A study conducted by Herman et al. (1997) indicated that lack of care from a parent during childhood sharply increased the likelihood of subsequent homelessness as did physical abuse. The risk of subsequent homelessness among individuals who experienced both lack of care and either sexual abuse or physical abuse was dramatically increased compared with subjects reporting neither of these factors. They concluded that adverse childhood experiences are powerful risk factors for adult homelessness. Effectively reducing child abuse and neglect may ultimately help prevent critical social problems including homelessness.

Herman et al. (1997) interviewed a nationally representative sample of 92 U.S. household members who had previously been homeless and a comparison group of 395 individuals with no prior homelessness. Their results lend strong support to the hypothesized link between adverse childhood experiences and adult homelessness, confirming what a number of previous studies have suggested. These results are consistent with a rapidly growing body of research indicating that abuse and neglect during childhood are also potent risk factors for a number of psychiatric disorders, including depression, anxiety, and substance abuse. It is also clear from the study conducted by Roman and Wolfe (1997) that what happens to children has a lifelong impact on them.

Many homeless women have had extremely traumatic childhoods and/or adult relationships (Browne, 1993). They are more likely than housed low-income women to have lived in foster care, a group home or institution, run away from home, been physically or sexually abused, and lived on the street or other public place (Lindsey, 1998).

According to a study conducted by Passaro (1996), several of the men interviewed felt like failures as men because of their inability to adequately support their families. Traditional gender norms appear to undermine the men's senses of self-worth. However many of the men interviewed were impoverished as children and seemed to be homeless as a result of structural barriers to education, healthcare, and employment.

The National Law Center on Homelessness and Poverty (1999) reported that homelessness is attributable to a dwindling supply of affordable housing, an increasing number of people living below the poverty line, recent rollbacks in support services, and the absence of health insurance for more than 37.9 million Americans. Supporting this fact is recent research that indicates that 5 to 15 million Americans have experienced an episode of homelessness during their lifetimes. Structural factors such as labor market changes, an inadequate supply of low-cost housing, and cuts in income assistance programs have created the social conditions in which homelessness has grown during the past 15 years.

Individual level risk factors (those personal characteristics and circumstances that make certain persons more vulnerable to becoming homeless under these conditions) have also been identified. These include poverty, gender (more males than females are

homeless), ethnicity (homelessness affects more African Americans than members of other groups), age group (most homeless persons are between 30 and 39 years old), and psychiatric and substance abuse disorders (Herman, Susser, & Ezra, 1997).

Given that homeless people are poor, the increasing numbers of people in poverty and the depth of their impoverishment over the past 2 decades have increased the pool from which homeless individuals and families are drawn. Incomes for the poorest fifth of single mothers in the United States sank from 33% of the poverty line in 1973 to 25% of the poverty line in 1983 and stagnated there through 1994 . Homeless families have high rates of many characteristics associated with enduring poverty, such as single parenthood, poor education, and dependence on welfare. But it is not clear that such characteristics distinguish homeless families from other poor families or that they affect families' ability to extricate themselves from homelessness. In a NewYork City study that examined predictors of entry into shelter, variables that were associated with enduring poverty were poor education and work history, lack of marriage, having a child as a teenager, and childhood poverty (Shinn & Weitzman, 1998).

In the findings of a service learning project by nursing students in an inner city mission, families of origin of homeless individuals were frequently unstable, isolated and isolating, violent, aggressive, and alcoholic. Spouse abuse and inadequate parenting were prevalent. Most homeless individuals reported little or no contact with their families of origin or created families. And opportunities to learn patterns of healthful interactions were not present within a family context (Gerberich, 2000).

Additionally, Gamache et al. (2001) indicated that research has consistently implicated disadvantaged childhoods, substance abuse and mental disorders that have an early onset as risk factors for homelessness. Furthermore, in the discussion of a follow-up study about veterans compared to non-veterans, the authors indicated that if youth alone is the distinguishing factor, reflecting adjustment problems encountered during the immediate period of transition back to civilian life, "we would expect the youngest cohort 10 years later to, once again, be the most at risk. However, if these men were part of a distinctly vulnerable cohort of veterans, aged 20-34 in 1987, we would expect to find that they were still over-represented one decade later, when they reached the ages of 35-44" (pg. 482).

The central issue addressed in the study was whether the period of highest risk of veteran homelessness continues to be in the youngest age group, or whether the highest risk has now shifted to middle adulthood, as the cohort, first identified in 1987, has aged. A decade later, the results point to a cohort effect. While attenuated, the new cohort of young veteran males is over-represented, perhaps due to the continued high prevalence of substance abuse problems in this group (Gamache et al., 2001).

However, informal supports, according to Gamache et al. (2001) may be less available to veterans due to separation from the family of origin during young adulthood that military service entails. Since military service represents a break in family ties, it may be that veterans who become homeless come from disadvantaged backgrounds and are unable to resume economically dependent positions in their families once their military service is over. This may especially be the case among veterans for whom

family ties were already strained, or for those who experienced severe adversity in childhood. Without a positive and supportive family of origin environment, veterans have less support in making the transition back from military to civilian life.

Nunez (1996) provided a somewhat unique view and places a portion of the blame on the system and a structural basis. He believes that the growing poverty rate in the U.S. has contributed to the problem of homelessness including the significant rise in the number of single parent families and the debilitating problems of violence, drugs and alcohol abuse. The economics of the 1980s forced Americans to tighten their belts and further "notched" the children of the working poor down the social and the economic ladder and a weakening social support system did not cushion their fall. The most paralyzing statistics of the "notched-down generation" is their incomplete education. He believes that education is the key to better family planning, more stable family structures and escaping poverty (Carter, 1998).

Many of the studies that have addressed the general homeless population developed similar conclusions in regards to the origins of homelessness. Again, one such study implicated macro level (systemic) variables as the culprit. In essence, the process of becoming homeless involved the interaction of a number of factors at both the macro and individual level. There is no one pathway into homelessness. Impoverished support networks were often connected to negative childhood experiences that contributed to poor interpersonal skills and unsupportive family of origin. Loss of employment and income were also factors that were found to be significant. Thus, the qualitative data suggest that it is the interaction between individual vulnerability and macro level factors

that result in a person becoming homeless (Morrell-Bellai et al., 2000).

In spite of this data, caution must still be exercised in forming conclusions as a result of the unclear mechanisms involved in some of the prior studies. The immediate situational precipitants of homelessness are difficult to interpret because of the absence of good comparison groups. Studies that ask detailed questions of the both homeless people and "vulnerable" but for the time being housed people would assist in creating a causal picture. For example questions that would result in providing feedback regarding why certain risk factors for homelessness, whether distal (in childhood) or proximate (precipitating), are more likely to occur, and with greater disruptive effect, in the lives of some people for whom the game seems rigged at the outset (Koegel et al., 1996).

It is the lack of this type of research that continues to create the discussion about the baffling numbers of homeless among African-American veterans. Much of the data available derives from studies that pertain to the non-veteran population. However, the limited amount of data available regarding veterans per se, generates questions about this population that warrants further exploration of the family of origin variables and the significance of these factors to African-American veterans. "To end homelessness, we must reckon with poverty. While poverty is not all there is to homelessness, there is precious little homelessness without it" (Baumohl, 1996, pg. xxi).

Informal Social/Family Support and Homelessness

If the speculative causes that contribute to the numbers of homeless among African-American veterans are to be explored, the viability of the social support system must be examined. This includes examining the influence of marital status and the accessibility of dependable family and friends before, during and after their active duty tenure.

Whether housed or homeless, people are inherently social in nature. Inevitably, through our social encounters with acquaintances, associates, friends, or family members, we acquire a web of interpersonal social relationships. These relationships form the basis of our personal social networks. Social networks are a vital part of human survival because they link individuals to society. Through their membership, networks can reach far beyond the individual's immediate scope to generate a variety of exchanges and supportive resources. In this manner, social networks become the vehicles through which individuals negotiate their social worlds. Even in the direst circumstances, people often manage to connect with others in order to maximize their own survival (Molina, 2000).

The few studies that have addressed racial differences in homelessness offer several clues to why extreme poverty in the African-American community should increasingly take the form of homelessness in the 1980s and the early 1990s, especially in light of the robust legacy of the black extended family. Although the evidence from these and other studies is still slim, a few themes recur (Hopper & Milburn, 1996).

First, like the pattern of African-American poverty generally, recurrent homelessness among the black poor tends to be less event-driven and more a matter of reshuffling. Reliance upon the "social capital" of kinship is common-place, both as an alternative to shelter and as a way of staving off the inevitable turn to emergency public relief (Hopper & Milburn, 1996).

Although extended families provided a wide range of support in the past, material, informational, emotional, and less frequently financial, they have been experiencing increasing strains of late and are no longer able to prevent literal homelessness as effectively. The increasing marginalization of inner-city areas and the resultant loss of support systems (both personal and economic) have depleted resources that traditionally buffered against the negative aspects of poverty (Hopper & Milburn, 1996). The two other themes, in this specific study, pertain to racial discrimination and employment and underemployment, which are factors that require a separate research focus.

It appears the people who become homeless have minimal support available to them prior to becoming homeless. Furthermore, the main precipitant for many is the loss of a significant support person through conflict or death. In some instances the conflict is precipitated by a last ditch attempt to prevent homelessness by doubling up with a relative or friend in an overcrowded living situation (Shinn, Knickman, & Weitzman, 1991 as cited in Morrell-Bellai et al., 1998). Shinn (1991) and her colleagues observed that most women who sought shelter had stayed with a relative or friend in the year prior but had "worn out their welcome."

Hopper and Milburn (1996) corroborated this claim. As was the case in the 1930s, the generosity of African-American extended households today stand out. But clearly even obligations rooted in kinship have their limits. Putting up with the demands of relatives or overcrowded situations is easier if they are expected to be short-lived.

The extended family functions as a survival mechanism for a people who have been deprived of adequate resources. It provides tangible help such as "material support, income, child care, and assistance in household tasks," as well as non-tangible support such as "expressive interaction, emotional support, counseling, instruction, and social regulation" (Wilson, 1989 as cited in Scannapieco & Jackson, 1996).

Floyd (1995) found that people who are homeless in a small city are homeless for the very same reasons they are homeless in a larger urban area. However, a lower portion of people in the smaller city attributed their homelessness to internal family dynamics and family instability than is the case in the larger city. {In the same study} this is particularly true amongst the black homeless population (Carter, 1998).

Community Care (2002) reported that divorce and relationship breakdowns are contributing to the number of hidden homeless people, according to the latest research from Homelessness Charity Crisis. A survey of 150 people, 101 men and 49 women, from across England found that 53% of respondents cited splitting up from their spouse or partner as the trigger for becoming homeless. Another 28% said they became homeless after their parents or step-parents threw them out of the family home and 16% said they were forced to flee because of verbal or physical abuse. Both the U.S. and England are known as super powers of the world. It is ironic that they also

appear to have more in common in regards to the problems of homelessness.

Although these studies are addressing the homeless population in general, these findings are similar to those found in veteran studies as well. According to Rosenheck et al. (1996), social isolation (for example being unmarried or having no one to talk with after discharge from the military) had a stronger relationship with homelessness than did psychiatric disorders (psychiatric diagnosis, PTSD, and substance abuse). Pre-military experiences had the strongest relationship to homelessness.

Finally, a study of 1,431 homeless adults in Santa Clara County, California, had a unique feature worth noting; it considered the elapsed time between discharge from the military and initial homelessness. Seventy-six percent of combat veterans and half of non-combat veterans first became homeless more than a decade after leaving military service (Rosenheck et al., 1996).

In a study conducted by Whaley (2002), comparisons were made of the demographic and clinical characteristics of African Americans with and without an immediate history of homelessness upon entry into a state psychiatric hospital. Contradictory results were reported. Four variables were studied including never being married, lifetime co-morbid substance abuse, severe paranoia, and high self-esteem. The patients who never married were less likely to have a recent history of homelessness. More men reported never marrying than women.

This finding seems counterintuitive given the importance of social support as a protective factor in psychosocial functioning. However, this finding is consistent with results from the National Survey of black Americans, which revealed that African-

American men who did not marry reported better mental health than their counterparts with other types of marital statuses (Brown, 1996).

Brown (1996) attributed the positive relationship between never marrying and mental health for black men to freedom from the stress and strain of family life under economically and racially oppressive conditions. It may also be that there is greater residential instability among African-American patients with families, instead of more stability among those who never married.

Homelessness cannot be narrowed to those sleeping in shelters or the street nor using the shelter system. These include many people who are "doubling up" or "camped out" with friends and relatives (Martin & Vacha, 1994 as cited in Johnson et al., 1995).

McCheseney (1990) found that lack of friends and relatives or the withdrawal of their support is a key factor in determining which poor families become homeless. Homeless studies, in general, have shown that the lack of social support and the tendency to isolate may be crucial factors in the cycle of homelessness, and the following study offers an important analogy about this hypothesis.

Social isolation is often proposed as an essential element of homelessness, but studies are mixed in whether they find homeless people to have poor social networks. Some evidence suggests that people on the verge of homelessness obtain substantial assistance from families and friends but eventually wear out their welcomes. Disruptions in social ties may also be important. Homeless adults often report having been abused or separated from their families during childhood.

Mothers in homeless families have often suffered domestic violence. This study

included measures of current social ties, which should reduce risk for homelessness, and domestic violence and childhood disruptions, which should increase risk. In the case of both behavioral disorders and poor social ties, bidirectional causation is plausible. That is, substance abuse or domestic violence may lead to homelessness, but homelessness may also exacerbate substance abuse, precipitate depression, or create estrangement from social networks (Shinn & Weitzman, 1998).

For example, according to Delisi (2000), there are two primary arguments about why persons are homeless and commit crime in this country. The classical argument is that people who are homeless are rational, free thinking beings, that, to a large extent, choose to be homeless, either directly or indirectly, through using debilitating substances (Benda et al., 2003).

This argument proposes that the typical scenario is that substance abuse often results in debilitation and dysfunction, and loss of social support. These personal and social losses frequently lead homeless substance abusers to engage in crime due to diminished capacities and the financial need to purchase alcohol and other drugs (Lurigio, Fallen, & Dincin, 2000).

Marital status, family relations, social support, employment and education are included among factors that insulate homeless individuals from criminal acts (Fox et al., 2001) and according to Benda (2003, 2002), these personal assets and social resources are thought to afford homeless persons opportunities in lieu of unlawful acts to survive on the streets. Familial problems and associations with those who engage in deviant behavior are well-established predictors of unlawful acts.

In their study of 303 homeless people and people at risk of homelessness in Cook County, Illinois, Johnson and Freels (1997) found that access to social and economic resources play a critical role in avoiding both homelessness and substance abuse. Loss of employment and the ending of a first marriage were both important risk factors for first homeless experience. People having lost a job, in particular were almost 5 ½ times more likely to subsequently experience homelessness. Availability of social resources, in this case, having been married, was a negative risk factor for subsequent drug abuse, and loss of economic resources (i.e. ever having lost a job) predicted alcohol abuse.

In a study conducted by Kingree et al. (1999), risk factors for homelessness were examined prospectively among participants in a substance abuse treatment program. Low levels of support from friends, greater depression, and recent substance use were bi-variately associated with homelessness two months following completion of the program. However friend support was the only factor associated with homelessness after controlling for other significant bi-variate predictors.

These findings serve as an important reminder that there are numerous pathways to homelessness and multiple independent predictors of substance abuse. Clearly, interventions attempting to address either of these conditions must also confront the restricted social and economic environments within which they flourish (Johnson & Freels, 1997).

According to Wakhisi (1995), a 1994 Columbia University homeless study estimates that 12.5 million people are white. They have stayed off the street only by moving in with family or friends at some point in their lives, for periods that ranged from

a few days to a year.

Yet, getting a handle on homelessness among African Americans and other minorities has been even more challenging. "Even though the majority of the homeless still appear to be white, what we find is that African Americans are over represented in the homeless population," said Nan Roman, director of the National Alliance to End Homelessness. Roman and others who work with the homeless say blacks make up anywhere between 30% to 40% of the nation's homeless (Wakhisi, 1995, pg. 15).

Bruce Link, who authored the Columbia study of people who were previously homeless, said blacks also might be homeless longer than their white counterparts. According to the data, said Link, 22% of blacks were homeless for more than one year as compared to 11% of whites. The irony of this data is that the African-American community long has housed relatives and friends through the various economic challenges that have come with being black in America (Wakhisi, 1995).

Baker (1994) stated that the close-knit, family-based social network is something of a cultural ideal in the United States, and, indeed, such strong ties can be key sources of emotional aid in times of crisis for all ethnic groups (Blazer, 1983; Griffith, 1985; Wellman & Wortley, 1989). The lack of a well-constructed public safety net makes support through the personal social network all the more critical in averting homelessness. Research on demographic variation in family support lends credence to the idea that women and children are more likely to be able to secure support from their families than are single adult men.

Rossi and Rossi (1989) found the strongest family obligation norms among kin to

extend to unattached daughters and mothers. Similarly, Rossi's (1989) study of homelessness in Chicago found young men less likely to believe that they could return to their families of origin for support than did young women.

Exhausting family resources is more likely when the family of origin itself is poor or in crisis (Piliavin et al., 1987) or when the homeless person presents an additional challenge to the family by suffering from a personal disability like substance abuse or mental illness (Rossi, 1989).

These social ills appear to be precursors to homelessness as a result of ruined familial and social ties. Low levels of support by friends or relatives is common among the homeless. Additionally, lack of protective factors such as having a relatively large social network and receiving cash assistance can be contributing factors to homelessness. Social poverty can be observed in many homeless persons, although its appearance differs from one sub-group to another; it often derives from long exposure to demoralizing relationships and unequal opportunities (Martens, 2002).

Men are more likely than women in homelessness research to evidence personal disabilities and are highly likely to come from poor families of origin and/or to have experienced foster home placement in childhood (Burt, 1992). These challenges to the availability of support, combined with kin-based norms of obligation that vary by gender, select against single adult men being able to turn as readily as do women to their own personal networks as a means of avoiding homelessness (Baker, 1994). Thus, a supportive social/family environment as well as being privileged to a supportive spouse or companion may affect the homeless status of African-American military veterans.

Individual Resiliency and Homelessness

The third and final variable that may have a significant impact on homelessness among African-American veterans is their ability to make sound and rational decisions whether during times of crisis, under pressure or under ordinary circumstances.

Benda (2001) reported that successful exploration of one's capacities in meeting life's challenges and feelings of self-esteem nurture the development of a sense of self-efficacy and resilience (Levy & Wall, 2000; Stein & Newcomb, 1999). Resilience refers to a repertoire of coping skills that allow people to handle formidable situations in life successfully. Resilience facilitates overcoming adversity, surviving stress, and rising above disadvantage (Aroian & Norris, 2000).

A resilient person can recover from defeat and perceive barriers to success as challenges to be overcome with perseverance and innovative thinking. In one study the focus was upon the number of times that hospitalized veterans were more prone to successfully maintain in the community after discharge, self-efficacy and resilience were expected to be strong predictors of survival in the community without re-hospitalization for those veterans with prior admissions. A systematic random sample of 600 homeless Vietnam veterans, ages 46 to 65, who abuse substances, many of whom are co-morbid with psychological afflictions was studied. Results indicated that the odds of remaining in the community longer without re-hospitalization were approximately two times greater with increases in attachments to family and friends. The odds of survival increased 3.30

for higher resilience, 2.51 for more self-efficacy, and double for self-esteem.

Although there is limited study of these strengths among homeless people, there is evidence in the literature on treatment of homeless substance abusers that resilience and self-efficacy are very promising targets of change for recovery from substance abuse and for elevated functioning (Boydell, Goering, & Morrell-Bellai, 2000; Levy, 1998, 2000 as cited in Benda, 2002a).

Scannapieco and Jackson (1996) indicates that resilience has been most often defined as an individual's ability to overcome adversities and adapt successfully to varying situations. All the definitions of resilience have a similar thread: the overcoming of some risk factor resulting in positive adaptation.

Minority status is a key characteristic of the homeless. Data compiled by Burt and Cohen (1989) showed the following ethnic distribution: 41% black, 46% white, 10% Hispanic and 3% other. The rate of black and Hispanic homelessness is highly disproportionate to their rates in the general population.

During the 1970s, African-American men were labeled an "endangered species." Thirty years later, African-American men face a multitude of health, sociopolitical, and psychological issues, and thus they continue to be an "endangered species." One factor that could account for their increasing scarcity and absence from family life is that the number and percentage of black men in prison is higher than it is for any other racial or ethnic subgroup (Braithwaite, Hammett, & Mayberry, 1996).

According to Braitwaite and Taylor (2001), although African-American men make up approximately 6 to 7% of the total U.S. population, they represent more than

60% of the two million persons under correctional supervision. African Americans are imprisoned at seven times the rate of whites. Thirty-three percent of black men between the ages of twenty and twenty-nine are either in jail, on probation, or on parole (Whitehead, 2000 as cited in Braithwaite & Taylor, 2001). These findings lend support to the endangered species hypothesis.

African-American homeless persons were found to be victims of racial discrimination according to First et al. (1988). Their primary explanations for homelessness were economic, that is, unemployment, even when they had more education and appeared better prepared to work than their counterparts with less education.

Forces that promote overt and covert discrimination in employment, housing, and access to health care resources marginalize their health status and reinforce the endangered species hypothesis. The increasing scarcity of African-American men and the imbalance in their ratio to African-American women severely threaten the vitality of the African-American family (Braithwaite, 2001).

Similarly, Belcher (1992) discussed the relationship between racial exclusion, severe and persistent poverty, and homelessness. He noted that the reason "many Afro-Americans in inner cities are vulnerable to homelessness is that they, because of blocked opportunities, often rely on the welfare system" (pg. 42).

Based on a sample of 900 homeless persons in St. Louis, North and Smith (1994) found that homelessness among African-American population was more often the result

of an inadequate welfare system and lower income; whereas for Caucasians it was more often the result of internal factors such as substance abuse and psychiatric illness.

According to Cohen et al. (1984), more than the basic needs is required to sufficiently address the needs of the homeless. Basic needs such as food, shelter, and clothing are being met; however, meeting other needs such as reliable income, clean and affordable housing, assistance with legal issues, assessment of job skills, and provision of necessary medical care often proves more challenging. The sense of failure and stress caused by the inability to secure basic needs and by the isolation and alienation of homelessness can lead to depression, anxiety and loneliness. These problems can hinder individuals in their efforts at successful functioning in their occupational, social, and leisure activities.

Belcher and Diblaso (1990), as well, reported these problems as blocking motivation for finding housing and seeking employment. These problems are especially detrimental for problem solving and coping among homeless persons with few financial and social resources and limited control over their environment (Ritchey et al., 1990 as cited in Lloyd-Cobb & Dixon, 1995).

Living on the streets day in and day out can take a psychological toll on a person. Isolation, alienation, and deprivation can create high levels of stress in the homeless (Belcher, 1988). Winkleby and White (1992) discovered that persons who had recently become homeless and reported no initial problems were likely to develop mental or substance abuse problems with the passage of time.

Belcher and DiBlaso (1990) found that the homeless accumulate more failures than successes in their lives, which in turn render them less able to successfully integrate themselves into the community. Many of the homeless view their lives as a series of failures. To gain the ability to change their behavior and develop new coping strategies, they have to feel capable of change (Blankertz & Cnaan, 1992 as cited in Lloyd-Cobb & Dixon, 1995). Following is a case and point.

In a study by Benda et al. (2003), crime was studied among 188 homeless persons who were in a Veteran Affairs Medical center program for substance abusers. The purpose of the study was to find out: (a) what proportion committed crimes and (b) what other problems, relational factors, and other personal attributes predict crime. Data indicated that 27% of these homeless veterans committed nuisance offenses, and 41% had committed crimes in the past year. The study found that physical and sexual abuse before 18 years of age increases the odds of committing crimes, whereas self-efficacy, ego integrity, and resilience decreased these odds.

While self-esteem has been studied among homeless people, the other attributes (self-efficacy, ego-identity and resilience) are relatively unexplored. Based on experience and theory about these attributes (Bandura, 1997), it seems reasonable to assume that homeless persons who find and explore alternatives to unlawful behavior are those who have a sense of self-efficacy, ego identity and resilience. For example, persons who are resourceful enough to exist on the streets in dire poverty without engaging in unlawful behavior are likely to believe they can be effective in alternative

courses of survival such as occasional day labor. Too, they bounce back from failures and continue to explore options available (Benda, 2001, 2003).

According to results of an exploratory qualitative study of focus group interviews (Applewhite, 1997), veterans expressed feelings of negative self-worth and their profound impact on their ability to cope. Although they expressed a strong desire to overcome their current problems, their lack of self-esteem was a barrier that often destroyed their will and determination to escape homelessness. According to the veterans, their negative self-esteem was the result of a multitude of setbacks in both personal and social interactions, such as the severing of family ties, the loss of peer support, and the loss of autonomy and self-sufficiency.

Yet, in research conducted by Bonanno, the results pointed to the differences in the genders and how they respond to controversy. Bonanno found that the two genders react differently to their loses. Men tend to remarry quickly as opposed to processing the loss. On the other hand, women use what resiliency experts call "positive reframing" and refocus on the benefits of their new life, including added freedom. Most studies on resiliency and bereavement also find that women handle grief better than men. This may be as a result of better support networks and the ability to reach out for help more readily (Jameson, 2002).

How people think affects how well they bounce back and avert depression. Thus, researchers at the University of Pennsylvania targeted children aged 10 to 12 who, based on their family situations, were at a high risk for depression. Half of the children attended 20 hours of classes to learn resilient ways of thinking (Jameson, 2002).

Researchers then followed up every six months and found that the course appeared to cut depression rates in half. Two years later, 44% of the kids in the control group showed signs of clinical depression, while only 22% of those in the resilience-training group did (Jameson, 2002).

According to the *Psychotherapy Letter* (1995), relationship between homelessness and substance abuse in mentally ill homeless people is complicated and interdependent, admits a group of researchers who tested a model to try to explain the relationship. Stresses in these individuals' lives seemed to influence their behavior, whether or not they were identified as using substances in relation to these stresses. The researchers proposed that one subgroup of patients used substances to cope with the stresses of being homeless, which they called the "stressor model." And a second subgroup had substance disorders that led to homelessness, the "non-stressor model." The therapists of the subjects of the study reported the stressors as the patients' drug use, housing, financial, social and psychiatric problems and the consequences of drug use. (Psychotherapy Letter, 1995).

Johnson and Freels (1997) supported this theory. The social adaptation or social causation perspective suggests that alcohol and drug abuse is more likely to be a consequence of homelessness. According to this view, abuse of alcohol and/or drugs is a means of adapting to life on the streets and may be a learned method of coping with the stresses of homelessness (Wiseman, 1978).

Johnson and Freels (1997) indicated that although there is little direct research bearing on this point, studies of non-homeless populations have demonstrated increased

substance use and abuse to be associated with a number of stressors, including job loss (Catalano et al., 1993), occupational stress (House et al., 1986), economic hardships (Pearlin & Radabaugh, 1976) and perceived stress (Silverman, Eichler, & Williams, 1987).

Although each of the previously discussed stressors is arguably of less magnitude than the state of homelessness per se, they are each, nonetheless, also a part of the homeless experience (Johnson & Freels,1997). Furthermore, given the disproportionate representation of people of color in the national homeless population, antipoverty agendas must also address the historic-structural issues of inequality contributing to their economic marginality (Molina, 2000).

According to Wong and Mason (2001), a homeless person in recovery living at the margins of society needs life skills as a foundation for entering the mainstream. Life skills education helps homeless persons to interact effectively with others, builds self-confidence, improves their capacity for civility, and supports them as they reach for their dreams.

Researchers now have some answers regarding why some people bounce back from setbacks while others do not. According to Shatte and other researchers (Jameson, 2002), there are traits that resilient people share. They include but are not limited to reining in emotion, making the best of the worst, trying a new point of view, thinking positive, reaching out for help and finding humor. While one does not need to have all of them to triumph over tragedy, having or cultivating a few could be beneficial.

The more one is connected with bigger things, the more resilient that person will be. Being involved with church, community or a larger cause helps make personal problems seem smaller. People who live self-absorbed, me-centered lives have a greater difficulty finding meaning in their life and don't weather trauma as well (Jameson, 2002).

According to Carbonnell, having the ability to think positive during controversy is a resilient trait. Less resilient people tend to believe that things will never change, as a result of the Simmons longitudinal study. This 25-year study funded by the National Institute on Mental Health has tracked 400 people, from ages 5 to 30, to gauge the factors that affect mental health (Jameson, 2002).

Additionally, reaching out for help is another resilient trait. Though it seems contradictory, resilient people are often strongly self-sufficient, yet they don't hesitate to reach out for help. In the Simmons study, Carbonell also found that resilient people identify those who are available, trustworthy and helpful, sometimes via a support group (Jameson, 2002).

Theoretical Framework

Although homelessness is not an insurmountable problem, it is a challenge (Hess, 2000). One of social work's distinguishing professional strengths is its recognition of the necessity of viewing the person-in-environment, an inherently systemic approach to assessing and solving human problems (Andreae, 1996).

Historically, the concept of person-in-situation has been an influential metaphor in social work practice and theorizing. This metaphor took on greater definition with the introduction of concepts from general systems theory in the 1960s and the 1970s. Deriving largely out of the physical sciences (for example, mechanics and cybernetics), systems theory gave social work a set of constructs that helped organize thinking about the effect of the social and material context on human behavior (Kondrat, 2002).

The systems framework is used as a means of broadening understanding of the complex situations in which social work practitioners must intervene. This approach plays a crucial role in social work education and practice, because its concepts help social work professionals view presenting problems as embedded in a larger context which shapes and maintains them (Kondrat, 2002).

The factors that contribute to a particular problem are interrelated and reciprocal; that is, they interact and need to be understood in terms of their interactions, not as isolated parts. The systems framework suggests that factors in the environment are important and is focused on solving practical problems in living and that can be understood at the individual, group, family, organizational, community, national, and global levels (Kim, 1995).

Systems thinking promotes a holistic, strengths-based approach to working with clients by providing a paradigm for understanding how complex interactions create and maintain behavior. This perspective shifts social worker's focus from personal pathology to what is problematic about a person's situation, and how the interactions of various components of a situation maintain less-than-optimal outcomes and discourage

optimal ones. The systems approach has the potential for providing a unifying perspective and language and an overarching framework for the social work profession (Chetkow-Yanoov, 1992).

For these reasons and because of the complex nature of and the many variables that may perpetuate homelessness, the systems theoretical framework was utilized. It has already made a major contribution to understanding the complex problems that social workers face today and can only serve to enhance the level of knowledge required to sufficiently address the issues of precipitating factors that may affect homeless African-American veterans.

Although rich descriptions of systems theory may be found in a variety of literatures, most scholars do not explicitly identify assumptions underlying the theory. Therefore, authors who have studied the framework explicitly will be relied upon to highlight the premises upon which the theory is constructed. There are four main assumptions of the systems theoretical framework. The first is based upon holism. The remaining assumptions state that systems are hierarchically organized; living systems are open, non-determined, and active, and human systems are self-reflective (Jurich & Myer-Bowman, 1998).

A fundamental assumption of systems theory is that of holism (Von Bertalanffy, 1968). According to Whitchurch and Constantine (1993), a system must be understood as a whole and cannot be comprehended by examining its individual parts in isolation from each other. Thus, the relationship among individual parts rather than the characteristics of the parts alone becomes the focus of attention when using a systems

framework, and the qualities of the whole emerge from this pattern among the parts. Thus, the whole is greater than the sum of its parts.

Von Berttalanffy (1975) described a system as a "set of elements standing in interrelation among themselves and with the environment" (pg. 25). Because the components of a system are interrelated, the behavior of each component affects all other components. This mutual influence is called interdependence. Unrelated and independent elements can never constitute a system (Skyttner, 1996).

Systems are hierarchically organized. They are nested within systems (Von Bertalanffy, 1968). He further asserts that at each level, the encompassing system emerges from the mutual interactions among the components, with the whole being greater than the sum of the parts. In turn, the broader system provides the context within which the meaning of the components may be understood.

Typically, the smaller units comprising a system are called subsystems or components, and the larger unit enclosing a system is called a suprasystem or environment. When components are identified as comprising a system, in essence, a boundary is being drawn. Boundaries define what is part of a system and what is excluded from the system. They mark the interface between the system and its subsystems and supra-systems. Systems are generally complex wholes made up of smaller subsystems. This nesting of systems within other systems is what is implied by hierarchy (Skytnner, 1996).

Living systems are open, non-determined, and active. The openness of a system refers to the degree to which it exchanges energy and information with its environment.

Open systems maintain themselves through such exchanges. All living systems are open at least to some degree, whereas only nonliving systems can be closed. Because closed system exchanges no information or energy with its environment, it is self-contained, and its evolution to a particular point can be determined from its initial conditions. In an open system-environment exchange, systems may evolve to the same point from different initial conditions and in different ways (Jurich & Myers-Bowman, 1998).

Von Bertalanffy (1975) referred to this as the principle of equfinality. He emphasized that living systems do not just passively respond to input from their environment; they also initiate transactions with the environment. Thus living systems are active as well as reactive. When systems are closed, boundaries are created. Boundaries are characterized by the degree to which they permit energy and information to flow between the system and its environment. A completely open system results in the loss of the system identity. At one extreme, boundaries do not permit any exchange (closed system) with the environment; at the other extreme, there is no impediment to transactions of any kind (open system) (Von Bertalanffy, 1968).

Thus, living systems may be best conceptualized as falling between the two extremes. Energy and information brought into the system from the environment are called input, and that which is exported from the system to the environment is called output. Input from the environment can shape the way a system functions (Jurich & Myers-Bowman, 1998).

Similarly, system outputs may shape the environment and the system's place in it.

Feedback refers to a circular process in which input is transformed by the system into output and the output is brought back to the system as input. Feedback allows a system to regulate its behavior and can be negative or positive. [An] important concept of the general system theory is mutual causation. It suggests that causality is often mutual, multiple and circular. In a book relating general systems theory to communication, Ruben and Kim claim that "causality is multi-lateral among parts of a sub-system, among systems and their environments" (Hendrickson & Tankard, 1997, pg. 40).

Human systems are self-reflective. According to systems theory, humans are able to self reflect on their behavior and interactions. Humans not only know, but they know that they know. This quality allows humans to examine their systems and consciously choose goals for guiding system processes. The interrelated objects constituting the system must be regulated in some fashion so that its goals can be realized. Regulation implies that necessary deviations will be detected and corrected. Feedback is therefore a requisite of effective control. Typical of surviving open systems is a stable state of dynamic equilibrium (Skyttner, 1996).

One of the most crucial elements of the systems theory indicates that the environment and the interactions that occur in that environment have a major and holistic effect on the system with which it is interrelated. In this case, it is the African-American veterans during their pre and post military periods. If the surroundings are not conducive to providing a healthy and psychologically sound environment, problems may develop and if they are already in existence, may be exacerbated. If veterans are not entering into and being discharged from the military with the proper guidance and social support

network, important decisions that they make during their transition into civilian life could cause adverse affects regarding their well being.

According to the systems theory, input from the environment can shape the way a system functions. In this case, African-American veterans and their childhood experiences as well as the caliber of their social support network before and after their military careers may prove to be the crucial factors that make or break their susceptibility to becoming homeless. For example, a system's feedback mechanism provides data about changes in the environment, so that the system can adjust to maintain its equilibrium. Because classical science assumes that these static elements are knowable and predictable for the observer, emphasis is then placed on material aspects of systems. Consequently, we find that elements of a systems are then analyzed based on which need they fulfill or conversely, do not fulfill (referred to as a dysfunction of the system) (Houston, 1999).

Another systemic factor that may have increased the experiences of homelessness among African-American veterans is the economic status of their family of origin and the environment in which they were raised. Income (exposure to constant poverty) could have been a determining factor or force in maintaining certain behaviors and attitudes before and after military service.

This boundary forces conceptualization of the environment as a causal chain of events in relation to the system. What this means is that system change is often activated by external forces; therefore, a system self-regulates to buffer itself from its environment. This thinking introduced the notion of inter-dependence that systems are reliant on, yet

are also constrained by, feedback from other subsystems (Houston, 1999).

In addition to growing up in poverty, lacking a needed mentor either through lack of the presence of one or both parents can result in a disadvantaged childhood. These factors could result in other adjustment problems. Thus, the possibility of an environment that may be less than ideal is created, an environment that has not prepared the veterans for and equipped them with the necessary qualities and characteristics that are crucial to making sound and rational decisions as adults

If this is the case, then according to the systems theory, energy and information are constantly being exchanged with the environment, which could result in undesirable situations for those veterans who are already in vulnerable positions as a result of their disadvantaged childhood. Not only will the possibility of a difficult transition into adult settings such as the military be increased, but, difficulty in transitioning to civilian life afterwards may develop also. These added stressors may possibly influence the veterans' ability to make decisions that could create situations that may result in their homeless experiences.

Thus, the possible creation of a domino effect occurs. The ripple effect is well illustrated by the following example which also demonstrates (a) how change at the system level can result from individual, and (b) how individual change can occur as a result of change in the larger system. The veterans' unstable childhood and lack of positive environmental factors stimulated change in their overall mental state and their ability to possibly cope with certain problems and issues. If the environment deteriorates, the possibility of the veterans' being affected are increased. Just as the ripple effect

causes change to reverberate throughout the system, systems also have a tendency to resist change. A system is characterized by established roles, relationships, and patterns of behavior that the system may wish to maintain (Keys, 1999).

The system as a whole is more powerful than an individual within the system. When an individual attempts to change, the system may operate against that change. The system's tendency to maintain the status quo, or the system's tendency toward homeostasis, may be more powerful than the ripple effect. This phenomenon further underscores the importance of engaging multiple systems to effect lasting change (Keys, 1999).

The energy being exchanged is negative; more environmental stressors are faced. The negative energy begins to outweigh the positive energy. The veterans find themselves in precarious situations, making irrational decisions, lacking the problem solving abilities and the resilience that are needed to maneuver even the worst of situations. During poster sessions at an American Psychiatric Association's annual meeting, therapists of 52 dually diagnosed patients receiving services from a community treatment team reported patients' drug use, current stressors (housing, financial, social psychiatric) and consequences of drug use as definite stressors or non-stressors and , possible stressors or non-stressors. Researchers found that stresses in these individuals' lives seemed to influence their behavior, whether or not they were identified as using substances in relation to these stresses (Psychotherapy Letter, 1995).

Problems can always be related to one or more of the main flows of matter, energy, or information in a living system. Furthermore, when the problem area is

identified, it is often found as a consequence of a malfunctioning subsystem. Three main system flows can always be identified in living systems, those of matter, energy, and information. All flows are entering the system and are to some extent stored. Inside the system, information processes regulate them. This is accomplished by continuously sensing the system's status. After feeding the processes within the system and simultaneously transforming their own content, the flows leave the system (Skyttner, 1997).

Albeit, some of these irrational decisions involve the use of alcohol and drugs. According to the systems theory, open systems continuously exchange energy, (i.e., information and other resources) with the environment. Input refers to the energy imported from the environment, throughput refers to the process by which the system acts upon this energy and output refers to the product exported into the environment (Skyttner, 1996).

Thus, input has the capacity to alert the system to the need for change, throughput the capacity to alter the system from within as it reacts to internal factors or environmental circumstances and output the capacity to alter the environment so that it is more conducive to the system's healthy functioning. All systems, if they are to attain their goal, must transform inputs into outputs. In living systems this transformation is mainly of a cyclical nature. In a closed system the inputs are determined once and for all; in an open system, additional inputs are admitted from its environment (Skyttner, 1996).

In the case of African-American military and other veterans, the use of alcohol and drugs before, during and after their military experiences is a type of negative energy

that may only serve to complicate an already chaotic system. Alcohol and drugs (external forces) can affect the mind and the body (the open exchange system) in a manner that prevents thriving and causes the system to fall into disarray. This may affect the ability of the veteran to maintain individual resiliency.

Instead of growing and developing and coping positively with environmental exchanges, the system exports more energy than it maintains, the system begins to lose vitality and decay ensues, possibly resulting in the failure to readjust to their civilian experiences and the subsequent exposure to literal homelessness. The systems theory has already made a major contribution to understanding the complex problems social workers face by emphasizing the important effects of environment and interactions.

Familial and informal social support factors include that support that is provided by close family and friends. However, support is more than the exchange of emotional aid. Social support also involves the exchange of guidance, useful information, and personal services, and material assistance (Baker, 1994).

Unlike more individually focused models that view cause and affect from a linear perspective, a systems paradigm views causality as interactive and circular (Worden, 1999). Again, veterans and the environments with which they are exposed, can mean the difference between success and failure in life, including their exposure to homelessness.

From the linear perspective, a specific cause is sought for a specific problem, however, from a systemic perspective, searches for patterns or connections are sought. The focus is on which forces maintain behavior not which forces caused it (Keys, 1999).

According to Kim (1995), the person is understood in terms of his or her interactions with other people and factors in the environment, such as a partner, parents, siblings, or boss. This statement insinuates that adjustment problems may not have been the lone cause of the chronic homeless problems experienced by African-American veterans, but all of the compounding factors that may have been lacking in the veterans' lives during crucial periods of growth and adjustment. Extenuating factors include access to social and emotional support and the numerous benefits that are generated as a result.

According to the systems theory, the environment and surroundings are key to the system's well being because a system is characterized by established roles, relationships and patterns of behavior that the system may wish to maintain or change. It is a form of input that influences output and eventually provides feedback to the system. The person is understood in terms of his or her interactions with other people and factors in the environment, such as a partner, parents, siblings, or boss. Every system has a set of boundaries which indicates some degree of differentiation between what is included in and excluded from the system (Skyttner, 1996).

Thus, the close-knit relationships and the support of the family or the lack thereof, may be the making or breaking point for the veterans as they cope with their various situations. This can definitely be an added stressor and a distraction if the family relationship is not supportive. Lack of a stable, positive and dependable social support system is crucial to the vitality of the system (the veterans lives and well-being).

Although the whole is composed of interdependent and interacting parts, the assumption is that it is always more than the particular parts. Thus, from a general

systems perspective, a homeless veteran with a tumultuous childhood and exposure to an unsupportive environment cannot be seen as simply a person who is addicted, has "burned bridges" and has caused his or her own demise. Rather, he or she must be seen as an intricately complex psychological, spiritual, and biological system who is connected to, and impacted by a variety of other social systems, for example an extended family, homeless advocates, particular neighborhood or community agencies, church, welfare, and other numerous systems. The important point is that all of these different systems are integral and interrelated parts of the veterans' lives (Kazemaek & Kazemek, 1992).

An open system is one in which there is a vital exchange between it and other systems. It is a system that grows and evolves as it receives input from its environment and generates output through various transactions with that environment. Martin and O'Connor (1989) say that an open system is viable because it is purposeful and self-directed. Its boundaries are permeable to outside influences, and it has many opportunities to interact with the environment. In addition, an open system that is self-directed is able to filter and select inputs and to channel them in a way that maintains its vitality (Kazemek & Kazemek, 1992).

A closed system, on the other hand, is one in which there is little or no exchange with other systems. Growth and evolution are restricted. A veteran who has been exposed to dysfunctional interactions or little positive communication among family members before, during and after military experiences, could be viewed as a closed system. A closed system is not always necessarily a dysfunctional system. It could be

active within the community, but is most concerned with preserving the system's identity. It may be purposeful and self-directed, but it is resistant to environmental input which may encourage growth and change (Kazemek & Kazemek, 1992).

Therefore, a secure family environment prior to entering the military could have resulted in a more emotionally stable veteran with a more healthy psychic. Also, if the relationship was positive during the military, the veteran may have utilized this factor as an outlet from the everyday stressors of military life and being away from home. Having a supportive and serene family environment with which to interact, could make a measurable difference in the life of a veteran. Having the love and the support of family and friends may have been crucial to the pre and post military transitions.

It is this type of environmental feedback that informs the system of its status and functioning; it may be used to steer the system's operations. The overall process of affecting and being affected by the environment is a form of feedback that affords the system the opportunity to take corrective action (Potts & Hagan, 2000).

However, in taking corrective action in certain situations, the system (veterans) has to be in a state of mind to make rational decisions. They must have the personal characteristics indicative of resilience and problem solving abilities. Because the systems theory indicates that humans are self reflective and able to choose goals to guide the system, it is safe to assume that African-American veterans who are mentally and psychologically healthy, are in a better position to make sound decisions more than those who are not. A healthy psychic symbolizes being able to choose goals that will positively guide the system.

It is clear that the vast majority of African Americans are seriously engaged in the process of self-betterment and the struggle for upward social mobility. The mental health implications of such driving efforts should be addressed in a manner aimed to reduce the psychiatric morbidity that results from race-based blocked opportunities. Energies must be focused on increasing the overall mental health of African-American communities by reducing stress and increasing resiliency among those blacks suffering the incapacitating effects of life in the United States (Braithwaite, 2001).

CHAPTER III

METHODOLOGY

Chapter III presents and explains the methods and procedures that were used in conducting the study. Sampling, data collection, measurement of the variables, validity and reliability and methods of data analysis are also discussed in detail.

Prior to initiating the instruments, a copy of the dissertation proposal, consent form and other application materials were forwarded to the Emory Institutional Review Board (IRB) and the Atlanta Veteran Affairs Medical Center's Research and Clinical Department for permission to conduct a human study on behalf of homeless veterans. Subsequently, all of the necessary contacts with the Department of Veteran Affairs research constituents and affiliates were made for the purpose of obtaining all of the signatures required to conduct the study and to ensure that all of the mandated forms were complete and in order. Additionally, the Clark-Atlanta University Institutional Review Board provided feedback and approval.

Research Design

To examine the research questions and hypotheses, the study utilized a qualitative research design of an exploratory nature. A non-probability sampling method

was used to select from the population of potential participants. During the September 2003 quarterly homeless service day, veterans who presented for services were asked to complete a survey. Additionally, other veterans who presented for services at the Atlanta Veterans Affairs Medical Center's (VAMC) homeless program during the two weeks following this outreach effort were solicited for participation also.

All veterans who were identified as homeless per the criteria established by the homeless program and who volunteered were eligible for participation in the study. The survey was self administered. All participants were given a cover letter explaining the study and assuring their confidentiality as well as voluntary participation. Upon completion of gathering the data, no other contact was made with the respondents. Multiple regression analysis is the statistical test that was utilized to analyze the data.

Description of the Site

The entire sample of participants was obtained from the Atlanta Veteran Affairs Medical Center's Healthcare for Homeless Veteran's (HCHV) program, located in Metropolitan Atlanta. Since 1987, the DVA Medical Center in Atlanta has aggressively reached out to homeless veterans through the HCHV program. As HCHV programs expanded, there has been an increased involvement with the community providers. Today, the HCHV program along with the Homeless Women Veterans Program is considered the entry point for all of the homeless veterans programs at the Atlanta VA.

This site was selected as a result of the convenience of obtaining the needed data for the study.

The bulk of the sample (95) was gathered at the September quarterly homeless service day for veterans. This is an event where veterans present for services in a community setting that is organized by the Atlanta Department of Veteran affairs Medical center to address the basic housing, medical, social and mental health needs of homeless veterans. The remainder (17) of the surveys was completed during the two weeks following the service day event.

Sample and Population

Selection of the subjects was solicited from the HCHV program and included walk-ins seeking services. At least ten (10) of the female subjects were recruited from the Homeless Women Veteran's Program (HWVP) and had been enrolled in the program for at least 30 or more days. All other participants were seeking services as non-enrollees.

Surveys and questionnaires were distributed to homeless veterans who requested services until 112 veterans had completed a survey. This method is called convenience sampling. It is a type of non-probability sampling and is not as scientifically based as other sampling methods. It entails selecting cases for study primarily because they happen to be readily accessible to the researcher (Yegidis & Weinbach, 2002).

Instrumentation

The instrument used in this study is a survey. It was constructed by the researcher and is compiled of questions from various existing survey instruments. The survey used gathered information regarding family of origin historical factors, family/social support and individual resiliency. Demographic data and intervening variables pertaining to the veteran's military profile and psychosocial history were gathered also.

Family of origin is defined as the family into which one is born or adopted (Goldberg & Goldberg, 1980). Family of origin historical data focused on the type of family environment in which the veteran was exposed. Questions regarding family of origin were developed by the researcher.

Family and social support are defined as an "omnibus term" relating to different aspects of social ties: information, emotional support, practical support, companionship, close confiding relationships, engagement in communal activities, objective and subjective assessment of such supports and satisfaction with it. The term 'support' implies that all such relationships are beneficial (Green et al., 2002). Family and social support data was measured by statements chosen from a portion of Hudson's (1990) Multi-Problem Screening Inventory (MPSI), which consists of 27 scales. Additionally, similar statements were chosen from the Multidimensional Scale of Perceived Social Support (PSS) (Procidano & Heller, 1983, as cited in Irving et. al., 1998).

Resiliency is defined as a repertoire of coping skills that allow people to handle

formidable situations in life successfully. Resilience facilitates overcoming adversity, surviving stress, and rising above disadvantage (Aroian & Norris, 2000). The resiliency variable was measured by five items that are similar to those on other scales that measure resilience (Aroian & Norris, 2000). Past use has resulted in an alpha of .89. However, the validity of this measure has not been established (Benda, 2001).

Homelessness is defined in accordance with the VA's HCHV's daily operating procedures. For the purposes of the program, the definition of homeless is one adopted by the Interagency Council on Homeless. It defines a homeless person as an individual who lacks a fixed, regular, and adequate nighttime residence; an individual who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designated for, or ordinarily used as a regular sleeping accommodation for human beings (Atlanta VAMC Memorandum, May 1998).

It was operationalized and measured in accordance with a portion of the Healthcare for Homeless Veterans' (HCHV) Program questionnaire (form X) that focuses on the living situation of the veteran upon presenting for service.

To ensure that the survey instrument provided clear and concise instructions, approximately five former program participants were asked to complete the questionnaire during the weeks prior to the start of the actual study. Oral instructions were given to

the participants, followed by the actual administering of the survey, with the finale including a question and answer session. Participants were asked to give their opinions regarding the length of the survey, clarity of the items included and other relevant concerns. There were no major concerns presented. The participants indicated that they understood the survey.

The title of the survey was "An Analysis of Precipitating Factors among Homeless African-American Veterans." The questionnaire consisted of seven sections with a total of thirty-six questions. Section I solicited demographic information about the characteristics of the participants. Section II addressed the military profile of the veteran. Section III addressed psychosocial information and section IV through VII addressed the dependent variable, homelessness, and the independent variables, family of origin factors, family/social support and individual resiliency, respectively.

A set of intervening variables was introduced to examine their impact on homelessness relative to the independent variables. These included demographics, military culture and psychosocial information. Section I, demographic data, consisted of six questions (1 through 7) addressing gender, age, ethnicity/race, marital status, education and place of childhood dwelling. Section II, military culture, consisted of seven questions (8 through 14) that pertained to the branch of service, military status, origin of military service, period of service, length of time in service, retiree status, and combat status. The third set of control variables, section III, addressed psychosocial information and included nine questions (15 through 23) pertaining to treatment for alcohol and drugs, psychiatric treatment, medical issues and financial support for

disabilities and pensions from social security and the Department of Veteran Affairs. These sets of intervening variables were utilized to describe individual or group characteristics about the sample population.

Section IV of the survey addressed the dependent variable of the study, homelessness, and consisted of three questions (24 through 24c) that pertained to the veterans' homeless status, the number of homeless experiences and the reasons for the present homeless episode. Section V addressed the independent variable, family of origin, and consisted of four questions (25 through 28) that inquired about the stability of the childhood environment, whether both parents were present and the source of the family income.

Section VI consisted of questions (29 through 31) and addressed whether the veterans have a supportive family, drug free friends and family and friends with whom they can share thoughts and feelings. Section VII, questions (32 through 36) addressed individual resiliency. The resiliency variable was measured by five item. The questions addressed the veterans' feelings regarding how well they can successfully cope with problems in life. The four point continuum Likert scale ranged from strongly agree, agree, disagree to strongly disagree, with the number four being positive and the number one indicative of poor resilient capability.

Treatment of the Data

To analyze the relationships among the independent, dependent and intervening

variables, a combination of descriptive and inferential statistics is utilized. Frequency distribution of the intervening variables was used to gain insight into the demographic, psychosocial, and military background of the respondents as these variables relate to the dependent variable, homelessness. These same descriptive analysis methods were utilized to measure the mean differences of the dependent and independent variables also.

Additionally, at the bi-variate level, multiple regression analysis (MRA) was utilized to determine the separate effects of the independent variables in regards to the dependent variable. Regression analysis procedures have as their primary purpose, the development of an equation that can be used for predicting values on some dependent variable (DV) for all members of a population (Mertler & Vannetta, 1999).

In multiple regression analysis, there are many methods of specifying the regression model equation. Standard multiple regression was the method chosen in this study. All independent variables (IV) are entered into the analysis simultaneously. The effect of each IV on the DV is assessed as if it had been entered into the equation after all other IV's had been entered. Each IV is then evaluated in terms of what it adds to the prediction of the DV, as specified by the regression equation (Tabachnick & Fedell, 1996 as cited in Mertler & Vannetta, 1999).

Limitations of the Study

The questions that measured family/social support and family of origin historical factors were selected from other instruments. Thus, there are no validity and reliability

measures for this portion of the survey.

The study was limited to those veterans who were available within the Atlanta metropolitan area and did not include a comparison or control group. This limits the generalizability of the study.

CHAPTER IV

PRESENTATION OF THE FINDINGS

The primary purpose of this study is to analyze some of the precipitating factors between homelessness and African-American veterans. This chapter presents the findings of the study and is organized into two sections. The first section presents the results of the descriptive analysis of data to include frequencies and percentages that are used to describe the participants' demographic characteristics, the intervening variables of the study and the dependent and the independent variables. The second section presents the results of the statistical results of the bivariate analysis of the research questions pertaining to family of origin factors, family/social support, individual resiliency and homelessness among African-American veterans.

Demographic Data

The demographic characteristics of the study sample are illustrated below in Table I. One hundred and twelve homeless veterans presenting for services from the metropolitan Atlanta VAMC HCHV program participated in the current study. The following information was acquired from the sample: gender, age, race, marital status, educational background and type of childhood environment.

Table 1

Demographic Profile of Study Respondents

Variable	Frequency	Percent
Gender		
Male	93	83.0
Female	19	17.0
Age Group		
21-29	1	0.9
30-38	2	1.8
39-47	39	35.1
48-56	55	49.5
Over 56	14	12.6
Ethnicity		
African American	102	91.1
Caucasian	7	6.3
Native American	3	2.7
Marital Status		
Never Married	29	26.6
Married	10	9.2
Separated	16	14.7
Divorced	48	44.0
Widowed	6	5.5
Education		
High School (GED)	45	42.5
Some College (Voc)	42	39.6
College Grad	19	17.9
Where I Grew Up		
Urban Inner City	55	50.0
Suburb	32	29.1
Rural	23	20.9

Table 1 cont.

Variable	Frequency	Percent
Homelessness		
Not currently homeless	10	9.2
Currently homeless	99	90.8

As table 1 indicates, 93 (83%) of the 112 respondents were male, African American 102 (91.1%) and between the ages of 48-56. Fifty-five (49.5%) of the respondents checked this age category, followed by 39 (35.1%) that were in the 39-47 age category.

Forty-eight or (44%), were divorced, followed by never married, 29 or 26.6%. Only 10, (9.2%) were married and sixteen (14.7%) were separated.

In regards to education, 45 or 42.5%, were high school/GED graduates, followed by 42 (39.6%) who acquired some college or vocational training and 19 (17.9%), were college graduates. Fifty-five (50%), grew up in an urban/inner city geographical location. Thirty-two or 29.1% and 23 (20.9%), grew up in the suburbs and a rural area respectively.

Ninety-nine (90.8%) of the respondents indicated being currently homeless. Ten (9.2 %) reported that they were not.

Intervening variables addressed the veterans' military profile in table 2 including branch of service, military status, military service, service period, total time served, retiree status, military occupational status and combat status.

The military profile of the respondents (table 2) indicated that a majority (69.6%) served in the U.S. Army followed by the U.S. Air Force 16 or 14.3%. Only one (0.9%) reported being an officer. However, 106 or 98.1% of the 112 respondents reported being enlisted. Nineteen (18.4%) reported being drafted and 83 (81.6%) reported a voluntary enlistment.

Table 2

Military Profile of Study Respondents

Variable	Frequency	Percent
Branch of Service		
Army	78	69.6
Navy	11	9.8
Air Force	16	14.3
Marines	7	6.3
Military Status		
Officer	1	0.9
Enlisted	106	99.1
Military Service		
Drafted	19	18.4
Volunteered	83	81.6

Table 2 cont.

Variable	Frequency	Percent
Service Period		
WWII	1	0.9
Korean War	1	0.9
Between Korean & Vietnam	2	1.9
Vietnam Era	63	58.3
Post Vietnam	29	26.9
Persian Gulf	12	11.1
Total Service Time		
Under 3 Years	38	33.9
3-6 years	49	43.8
7-10 years	12	10.7
11-14 years	5	5.4
15 years & up	7	6.3
Military Retired		
Yes	12	11.4
No	92	88.6
Military Occupational Specialty		
Administration	16	14.8
Clerical	5	4.6
Communications	6	5.6
Engineering	9	8.3
Food Services	7	6.5
Infantry	22	20.4
Maintenance	8	7.4
Medical	6	5.6
Other	29	26.9
Combat Duty		
Yes	29	29.6
No	68	70.4

Sixty-three or 58.3% served during the Vietnam era followed by post-Vietnam era 29 (26.9%) and Persian Gulf veterans 12 or 11.1% respectively. Forty-nine (43.8%) of the veterans reported serving at least three to six years and thirty-eight (33.9%) reported serving less than three years. Only 12 (11.4%) reported being retirees.

Table 3 below displays the descriptive statistics of the dependent variable, homelessness. It includes the length of the homeless episode, the number of times experiencing homelessness and the reasons for the homeless episodes.

Various military occupational specialties (MOS) were reported, however the "other" category (26.9%) received the most responses. Surprisingly, infantry 22 or 20.4% was the second highest category reported, followed by administration 16 (14.8%). The "other" category responses identified "supply" (n = 9) as the MOS, followed by a diverse number of responses including military police, welder, engineering, social services and fire protection. Only 29 (29.6%) of the respondents reported combat duty.

Table 3

Homelessness Profile of Study Respondents

Variable	Frequency	Percent
Homelessness		
Not currently homeless	10	9.2
One night – less one month	13	11.9
One month – less than six months	18	16.5
Six months – less than one year	28	25.7
One year – less than two years	16	14.7
Two years and up	24	22.0
Number of Homelessness Episodes		
Never	4	4.1
One time	28	28.9
Two times	30	30.9
Three times	16	16.5
Four times	8	8.2
Five times	7	7.2
Six times	2	2.1
Ten times	2	2.1
Reason for Homelessness Episodes		
Addictions	20	26.6
Unemployed	28	37.3
Medical Problems	5	6.7
Family Problems	3	4.0
Relocation	5	6.7
Other reasons	14	18.7

Table 4 displays the results of another intervening variable, the respondents' psychosocial status. Information was solicited pertaining to alcohol and drug treatment, as well as psychiatric and medical treatment.

Table 4

Psychosocial Profile of Study Respondents

Variable	Yes #	Yes %	No #	No %	Total #	Total %
Alcohol Treatment	69	63.3	40	36.7	109	100.0
Drug Treatment	80	75.5	26	24.5	106	100.0
Treatment for Mental Problems	57	52.3	52	47.7	109	100.0
Treatment for Medical Condition	66	60.6	43	39.4	109	100.0

The psychosocial profile of the respondents (table 4) indicated that they had received treatment for alcohol 69 (63.3%), for drugs, 80 (75.5%) and for mental problems 57 (52.3%). Specified mental problems included depression (n = 20), post traumatic stress disorder (n = 10) and schizophrenia (n = 5). Sixty-six or 60.6% reported ongoing medical problems including diabetes, high blood pressure, hepatitis C, gastrointestinal problems, orthopedic problems, seizures and strokes.

Table 5 displays data pertaining to the respondents' financial status in regards to disability compensation, pensions and other forms of public assistance. The compensation is for mental, medical and other financial assistance granted for ailments not related to active duty service.

Table 5

Financial Support Profile of Study Respondents

Variable	Yes #	Yes %	No #	No %	Total #	Total %
Public Assistance	11	10.0	99	90.0	110	100.0
Psychiatric Service Connected Pension	9	8.1	102	91.9	111	100.0
Other Service Connected Pension	19	17.4	90	82.6	109	100.0
Non-Service Connected Pension	13	11.7	98	88.3	111	100.0
Non-VA Disability (SSI – SDI)	14	13.0	94	87.0	108	100.0

In regards to financial support, table 5 indicates that only 11 (10%) report receiving some kind of public assistance. Nine or 8% report being service connected for a psychiatric/mental disorder and 19 (17.4%) report receiving a pension and being service connected for a condition unrelated to mental health. Thirteen (11.7%) report receiving a non-service connected pension and 14 (13%) receive social security disability.

Precipitating Factors of Homelessness

Table 6 displays the first of three independent variables upon which this study is focused. Family of origin include information pertaining to whether the respondent grew up in a stable family environment, was raised by a single parent and received public assistance.

Table 6

Homelessness Indicators for Family of Origin among Military Veterans

Variable	Yes		No		Total	
	#	%	#	%	#	%
Grew up in a stable family	76	74.5	26	25.5	102	100.0
Grew up in an un-stable family	31	39.7	47	60.3	78	100.0
Raised by a single parent	40	42.6	54	57.4	94	100.0
Family received public assistance	25	22.9	84	77.1	109	100.0

Family of origin data (table 6) indicated that a majority of the respondents in each category reported growing up in a stable family 76 (74.5%) with both parents 54 or 57.4%. Thirty-one (39.7%) reported growing up in an unstable family. Only 25 or 22.9% reported receiving public assistance (welfare, food stamps etc.) during their childhood.

Table 7 displays the second independent variable, family and social support. Respondents addressed questions pertaining to available support from family and friends in their lives.

Table 7

Homelessness Indicators for Family and Social Support among Military Veterans

Variable	Yes #	Yes %	No #	No %	Total #	Total %
Supportive Family	60	55.6	48	44.4	108	100.0
Drug Free Friends	90	83.3	18	16.7	108	100.0
Family and Friends to confide in	74	68.5	34	31.5	108	100.0

Table 7 shows that family and social support were available for many of the respondents at the time that the survey was administered. Sixty (55.6%) reported having a supportive family. Ninety (83%) indicated that they have friends who do not use drugs. A high percentage (67.6%) or 73, reported having family and friends with whom they can share their thoughts and feelings.

Table 8 displays the final independent variable, individual resiliency. Questions pertaining to the respondents' ability to handle problems and setbacks in life are addressed.

Table 8

Homelessness Indicators for Individual Resilience among Military Veterans

Variable	Disagree #	Disagree %	Agree #	Agree %	Total #	Total %
Able to overcome difficulties quickly	38	35.5	69	64.5	107	100.0
Obstacles do not hinder accomplishments	35	32.4	73	67.6	108	100.0
Able to successfully cope with situations	41	38.7	65	61.3	106	100.0
Can bounce back quickly from failures	45	41.7	63	58.3	108	100.0
Can endure setbacks and still succeed	27	24.8	82	75.2	109	100.0

The final independent variable, individual resiliency, indicated the following descriptive results in table 8. Although their responses were not an indication of "strong" opinions, nevertheless, a large number (47.7%) for R1, 54 (50.0%) for R2, 46 or 43.4% for R3, 49 (45.4%) for R4, and 57 or 52.3% for R5 respectively "agreed" that they have the resiliency to cope with the problems and setbacks that life sometimes present (see table 8 above).

Research Questions and Hypotheses

This study encompasses the following research questions and null hypotheses. To examine the separate effects of the three independent variables on the dependent variable, bivariate analysis is employed. The statistical analysis utilized is multiple

regression analysis. This statistical test was selected based on its appropriateness for the level of measurements used for each study variable.

Research Question 1:	Is there a relationship between an unstable childhood and homelessness of African-American military veterans?
Null Hypothesis 1:	There is no statistical significant relationship between an unstable childhood and homelessness of African-American veterans.
Research Question 2:	Is there a relationship between a supportive family and homelessness of African-American military veterans?
Null Hypothesis 2:	There is no statistical relationship between a supportive family and homelessness of African-American military veterans.
Research Question 3:	Is there a relationship between individual resiliency and homelessness of African-American military veterans?
Null Hypothesis 3:	There is no statistical relationship between individual resiliency and homelessness of African-American military veterans.

A multiple regression analysis was conducted to evaluate whether there is a relationship between homelessness, (the dependent variable) and family of origin, family and social support and individual resiliency, (the independent variables). Table 9 displays the significance of the MRA correlations matrix of the dependent variable and the independent variables. The correlation probability is significant at the 0.01 level (2-tailed). According to the data analysis results, neither of the independent (predictor) variables are significantly correlated to the dependent (criterion) variable. Family of origin's p value is equal to –.043, family /social support is equal to .030 and individual resiliency is equal to -.059. The Pearson's correlation coefficient probability for both family of origin and individual resiliency were both negative. All probability results are greater than the 0.01 level of significance for each independent variable that was analyzed, thus indicating lack of a statistically significant relationship to the dependent variable, homelessness.

However, the data does suggest that there is a small but statistically significant relationship among the independent variables, specifically family of origin and family/social support with a correlation probability of .256. Additionally, a similar but weaker relationship exists between individual resiliency and family/social support, with a correlation probability of .475.

Table 9

Multiple Regression Analysis Pearson Correlations

		Homeless	Indv. Resili	Family of Origin	Family/Soc Support
Pearson Correlation	Homeless	1	-.043	.030	-.059
Sig. (2-tailed)			.651	.756	.534
N		112	112	112	112
Pearson Correlation	Family of Org.	-.043	1	.256	.056
Sig. (2-tailed)		.651		.006	.560
N		112	112	112	112
Pearson Correlation	Family Soc/Supp	.030	.256	1	.475
Sig. (2-tailed)		.756	.006		.000
N		112	112	112	112
Pearson Correlation	Indv. Resiliency	-.059	.056	.475	1
Sig. (2-tailed)		.534	.560	.000	
N		112	112	112	112

$p \leq .01$

Table 10 provides the R (1.07), R2 (.011), adjusted R2 (-.016), and standard error (1.56590) for the overall regression model. The R2 indicates that less than 2% of the degree of the variance of homelessness can be explained by the combined influence of the three independent variables, family of origin, family/social support and individual resiliency, thus further supporting the null hypotheses of the study.

Table 10

Multiple Regression Analysis Model Summary

Model	R	R Square	Adjusted R Square	Std Error of the Estimate
1	.107	.011	-.016	1.56590

Table 11 presents the ANOVA summary table. This test examined the degree to which the relationship between the DV and the IV's is linear. This table indicates that the amount of variance explained by the regression equation is not statistically significant, as shown by the F value (.413) and its associated p value (.744). There is no linear relationship between family of origin, family/social support and individual resiliency and homelessness. Thus, the independent variables are not considered to be statistically significant in predicting homelessness among African-American military veterans.

Table 11

Multiple Regression ANOVA

Model		Sum of Squares	df	Mean Sq.	F	Sig
1	Regression	3.038	3	1.013	.413	.744
	Residual	264.819	108	2.452		
	Total	267.857	111			

In summary, a multiple regression analysis was conducted to evaluate how well family of origin, family/social support and individual resilience predicted homelessness among African-American military veterans. There was not a significant linear relationship between homelessness and the set of independent variables, $F(3,108) = .413$, $p\ (.744) > .001$, thus the null hypotheses that family of origin, family/social support and individual resiliency will have no statistically significant relationship to homelessness are supported. Less than 2% (.011) of the variance of homelessness was accounted for by family of origin, family/social support and individual resiliency.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The analysis was designed to answer the question regarding the relationship between homelessness among African-American veterans and family of origin factors, family/social support and individual resiliency.

The conclusions and recommendations of the research findings are presented in this chapter. Recommendations referencing future discussions are proposed for policymakers, social workers, practitioners, administrators and advocates for the homeless.

An exploratory research design was selected to analyze the relationships between the three independent variables and the dependent variable. The selected site was the Atlanta Veteran Affairs Medical Center. The sample population consisted of 112 homeless veterans seeking services from the Healthcare for Homeless Veterans Program. The instrumentation selected was the survey, which consisted of 36 items. The statistical treatment of the data employed descriptive statistics, which included frequency distribution, percentages, mean, standard deviation and bivariate analysis utilizing Multiple Regression Analysis (MRA).

A descriptive analysis of the demographic data revealed that 91.1% of the respondents were African-American males (83.0%) between the ages of 48-56 (49.5%).

Forty-two percent reported marital status as divorced or never married (26.6%). Together these numbers comprise 68.6% of the respondents indicating that the majority of the homeless who participated in this study is single.

The results support past literature and studies that indicate that a majority of the homeless are single African-American males. According to Link et al. (1994), people who were young, single, male and African-American were over-represented among the population of currently homeless people. These numbers are consistent with the veteran population in this study as well. They appear to have obtained at least a high school education/GED (42.5%). Forty-two (39.6%) indicated having some college and/or vocational training. Only 17.9% reported being college educated. And 50.0% reported being raised in an urban area or the inner city.

The military profile of the homeless veterans indicated that most (69.6%) had enlisted in the army. Only .9% were of an officer status during their active duty tenure. Volunteers accounted for 80.6% of the respondents and 58.3% served during the Vietnam Era, between 8/64 – 4/75. Three to six years was the major category representing the number of years of active duty (43.8%) and only 11.4% were retirees. Infantry was the military occupational specialty (MOS) most reported (20.4%, however only 29.6% reported being exposed to combat.

The majority of the MOS responses came from the "other" category (26.9%). Although the answers varied, some of the responses were actually jobs that could have been identified under the specified categories on the survey, however because of a matter

of interpretation, the respondents made a decision to list "other" as the choice. "Supply" was the main response listed in the "other" category.

This study is consistent with other findings regarding the age category of most homeless veterans, i.e., Vietnam and post Vietnam era veterans. Rosenheck (1994) indicated in his studies that a large portion of the homeless veterans' population are Vietnam era veterans.

The psychosocial profile data yielded information that the researcher considers to be consistent with findings in the general homeless population also. However, the study revealed additional information about the financial aspect of the homeless veteran's circumstances and indicated that those veterans in this study, although non-combat, appear to be experiencing the same kinds of health and mental health problems as combat veterans in prior studies.

Data collected in this study indicated that only 10% of the homeless veterans surveyed receive public support such as welfare, food stamps etc. In regards to a service connection for mental health and non-mental health problems, only 8.1% and 17.4% respectively, receive financial compensation from the federal government.

Data also revealed that 63.3%, 75.5% and 52.3% of the homeless veterans had been treated for alcohol, drugs and psychiatric problems respectively. Additionally, 60.6% reported experiencing an ongoing medical problem. Rosenheck and Koegel (1993) found that among the major problems experienced by homeless individuals are severe mental and physical illness, alcohol and other substance abuse, chronic unemployment, and menial jobs and wages.

Although many other studies corroborate these findings, very few studies have addressed the financial aspect of the homeless veterans' situation except in terms of whether the veteran is employed or unemployed. The viability of the veterans eligibility for a pension or other government assistance is an aspect of the psychosocial assessment process that may be lacking.

The DVA provides financial compensation for those veterans who have filed claims and provided medical evidence of an illness, mental or physical disability that is directly related to their service in the military. Support is received after approval is given by the disability pension rating board.

Non-service connected pensions are those that provide financial support to those veterans who served during specified periods of active duty and are in need of assistance for a physical or mental disability that is not related to their active duty or military tenure, and only 11.7% of the homeless veterans surveyed reported receiving one. A slightly larger number (13.0%) reported receiving social security benefits that are available to those veterans who meet the criteria established by the Social Security Administration.

Considering the percentages of veterans in this study (at least half or more) who reported being mentally and physically challenged, the numbers indicating financial support of some kind do not statistically compare. Many of the problems specified in the mental health and the physical health categories are the kinds of problems that are debilitating and could prevent individuals from leading normal lives and maintaining as productive citizens in society.

In an effort to survive, money is a necessity. If veterans are affected by chronic

mental or physical illnesses, chances are their ability to maintain stable employment is null and void. Thus, the cycle of homelessness begins and continues. The present study provides new information and justification to expand the scope of future studies to include a thorough assessment of homeless veterans' psychosocial history and how it relates to their eligibility to receive financial compensation.

Additionally, of interest is the data that reflects the combat and health status of those respondents in this study. Over half, (69.4%) reported non-combat duty, yet similar numbers indicated that mental and physical problems were issues, 52.3% and 60.6%, respectively. This is noteworthy because some prior studies indicate that veterans reported problems with seizures, depression, schizophrenia, adjustment issues, post-traumatic stress disorder (PTSD), and flashbacks and the compounding effects of these problems on their daily struggle for survival. Most psychosocial and psychiatric problems came from veterans who experienced combat duty in Vietnam (Applewhite, 1997). However, these same problems were reported by the veterans in this study. Perhaps another area of research that needs to be addressed regarding this sub population of veterans.

Descriptive analysis of the respondents' homeless profile indicates that 62.4% had been homeless for at least six months to over one or more years. Specific reasons given included addictions, lack of employment, health problems and family problems. This data also show indications that a large number of the respondents have been homeless more than once.

In fact, the data reflects that at least 65% of the sample population studied reported being homeless at least twice and as many as 10 times previously. Breakney (1997) indicates that the homelessness of a mentally ill man may have its roots in his childhood home. Prospectively, also, the way the same homeless man is treated now will affect the likelihood of his becoming homeless again two years later. Undoubtedly, there is a problem that could possibly be tied to the bureaucratic structure of the system and the programs providing services as well as other less obvious factors. Unquestionably, more research is needed to analyze the possible factors that are strongly related to this issue.

The data in this study show numbers that add credibility to past research reports suggesting that perhaps new service delivery models are needed as well as a move beyond studying homeless people, their relationship to society and the causes of homelessness to another strategy. The development of clinical measures appropriate for assessing secondary problems of homeless people and evaluating the effectiveness of programs and services are crucial to moving forward regarding preventing future homelessness (Jonhson & Cnaan, 1995).

Again, data from this study show that at least 62.4% of those surveyed have been in the homeless cycle for at least one to two or more years, with multiple bouts of homelessness. This data has revealed information about the historical psychosocial profile of homeless veterans that has prompted attention of their plight to another dimension regarding the fight against prevention. For example, the McKinney Act has created programs to address homelessness, however, it has responded to emergency measures and the symptoms of homelessness over the years, according to the National

Coalition for the Homeless (1999). Clearly, after 20 years of addressing this public health issue on the federal level, with only minimal results, another approach is needed. The statistics support this point. Following is an individualized presentation of each research question.

Research Question 1: Is there a relationship between an unstable childhood and homelessness of African-American military veterans?

At the bivariate level, the analysis of the relationship between an unstable childhood and homelessness are not statistically significant. Although this finding is inconsistent with some of the literature reflected in prior studies, it serves as a basis for other studies that have placed the culprit of homelessness on the system and a structural basis. The interaction between individual vulnerability and macro-level factors results in a person becoming homeless (Morrell-Bellai, 2000).

Koegel et al. (1996) indicated that caution must be exercised in forming conclusions as a result of the unclear mechanisms involved in some of the prior studies. The immediate situational precipitants are difficult to interpret because of the absence of good comparison groups.

There are many who have grown up in unstable families; however, they have somehow managed to beat the odds by persevering beyond the walls of poverty and proceeding to make their lives successful and rewarding. On the other hand, there are

those who have grown up in stable families and still managed to become homeless. What is it that destines one military veteran to face homelessness while another with similar characteristics and traits maintain as viable productive citizens of society? Perhaps the answer is simple; however, the need for additional studies, involving various comparison groups, is warranted.

Research Question 2: Is there a relationship between a supportive family and homelessness of African-American military veterans?

Results of an analysis of the relationship between family and social support and homelessness showed that there is no statistically significant relationship. This finding contradicts prior studies, which indicate otherwise. Kingree et al. (1999) conducted a study that examined risk factors for homelessness. This study found that low social support is a potent predictor of homelessness. Low levels of support from friends, greater depression, and recent substance abuse use were bivariately associated with homelessness two months following completion of the program. However, friend support was the only factor associated with homelessness after controlling for other significant bivariate predictors.

A large number (over 50% in each category) of the respondents indicated that in spite of their homeless status and the circumstances that they were facing, they were privileged to a supportive family, drug free friends as well as family and friends with

whom they could share their thoughts and feelings. Again, this data is a strong contrast to recent literature and past studies about social support and homelessness.

This could be attributable to the fact that many of the respondents in this study are coping with addictions. Anyone who works with clients who are actively using substances are aware that many times they choose to be estranged from their families out of shame and guilt. Some homeless addicts and alcoholics prefer to keep their distance from those who are closest to them, often times because of behavior that they are trying to conceal or shield from their love ones.

Additionally, although many families of addicts and alcoholics are supportive of their addictive family members, that support does not always involve providing shelter from the elements. There may be other forms of support such as staying involved in some aspect of their treatment, providing a place to shower periodically or other kinds of assistance. However, worn out welcomes, broken promises, thefts of personal belongings and other anti-social behavior prohibit some family members from playing more traditional roles in the homeless veterans' lives. The veterans are aware that it is not them personally, but it is their behavior and their habits that their family and friends do not support.

Research Question 3: Is there a relationship between individual resiliency and homelessness of African-American military veterans?

Results of the final independent variable indicated that there is no statistically significant relationship between individual resiliency and homelessness among African-American veterans. All of the five questions that asked the respondents about their abilities to succeed after failures or to cope with stressful situations positively, indicated that they believe that they have the resiliency to cope with any setbacks that they experience in life.

Although the data indicated that those African-American veterans in the study possess individual resiliency, nevertheless, their present living situations indicates homelessness. Thus, supporting that in this study, lack of individual resiliency among African-American veterans is not necessarily a direct contributor to homelessness. For each of the questions, most of the respondents agreed that they were able to overcome difficulties quickly, proceed to accomplish goals despite obstacles and cope successfully with situations in life. The remaining two questions asked about their ability to bounce back from failures quickly and continue until successful and whether they can endure a lot of setbacks and still try to succeed in life. The answers ranged from strongly disagree to strongly agree. Although most of the respondents (43.4% and up) agreed that they were resilient, less than 25% and below either strongly agreed, disagreed or strongly disagreed.

The strongest relationship, although not significant, occurred with IR2, "I do not allow obstacles to keep me from accomplishing what I want to do." This finding is indicative of an exploratory qualitative study by Applewhite (1997), who interviewed homeless veterans. Although they expressed a strong desire to overcome their current

problems, their lack of self-esteem was a barrier that often destroyed their will and determination to escape homelessness. They believed that their negative self-esteem was the result of a multitude of setbacks in both personal and social interactions, such as the severing of family ties, the loss of peer support, and the loss of autonomy and self–sufficiency.

Although the variable, resiliency, is not found to be directly related to the plight of homeless African-American veterans in this study, research has shown that personal characteristics are more influential than variables related to the military history of the veterans. If not resiliency, perhaps other unexplored traits are lacking on the veteran's behalf and increasing their susceptibility to homelessness.

In the study conducted by Rosenheck and Fontana (1997), four preliminary variables, year of birth, physical and sexual abuse, traumatic experiences other than physical or sexual abuse, and placement in foster care before the age of 16, had direct effects on homelessness. Conduct disorder in childhood had a substantial indirect effect on homelessness through its impact on several war zone and post-military variables, especially substance abuse. Vulnerability to homelessness seems to accumulate over time and involves multiple aspects of psychiatric illness, social isolation, and antisocial conduct.

Many of the respondents admitted to more than one episode of being homeless, and have obviously bounced back from their experiences and consider themselves survivors as a result. Those who are new to the homeless experience may not feel so resilient, because of their unfamiliarity with the process. The data shows that very few of

those surveyed had experienced homelessness less than two or more times. Most had long histories of homelessness.

The final independent variable, individual resiliency, showed that the respondents believe that they can cope with stress, hardship and setbacks with no problems. In each of the five questions addressed, consistency was shown in the respondents' answers about their abilities to be successful in spite of their circumstances

Implications

Further research is needed to address the plight of African-American homeless veterans who present with a complex profile of problems and needs. Although the variables analyzed in this study were found to be unremarkable in regards to homelessness. there was one significant finding in regards to the independent variables, specifically family of origin and family/social support and family/social support and individual resiliency. The relationships were significant but minimal.

Additionally, the data listed in the psychosocial profile yields some results that could be directly related to the homeless status of the respondents. Because the participants report being treated for alcohol, drugs, mental conditions and medical problems, co-morbidity issues should be at the forefront of future discussions of policy makers, social workers and other homeless advocates regarding homeless veterans.

In addition to the complexity of treating such a unique group of veterans, those who participated in this study revealed additional information that is crucial to their future well-being and their ability to avoid subsequent homeless experiences. This is

reflected in the financial support section of the psychosocial data. The number of respondents reportedly receiving financial assistance, in particular, from the Department of Veterans Affairs is only nine (9) for a psychiatric service connection, 19, for a service connected pension unrelated to mental health and 13 for a non-service connected pension. Yet they reported experiencing various mental health and medical problems.

When homeless veterans are experiencing mental health and/or medical problems, it may be difficult for them to access financial assistance. These veterans who are not in a position to maintain stable employment and who may require that extra boost of financial support to assist with maintaining in their basic needs for daily living, like the ones vulnerable to veterans being homeless and remaining homeless. The data is symbolic of all the problems and issues that homeless veteran advocates must thoroughly address from every angle if homelessness is to be eradicated.

Lack of a thorough psychosocial assessment that fails to identify the unique service needs of these veterans will only result in perpetuation of the veterans homeless circumstances. Included in these circumstances is failure by the system to identify chronic mental and physical health issues, untreated physical and mental health problems, inability to secure financial compensation as a result of unidentified and untreated disabilities, thus a never ending cycle of homelessness.

Failure to address this issue from an administrative standpoint could have just as much of a far-reaching effect than the clinical aspect. Program evaluation and assessment of the effectiveness of those programs that provide specific services to homeless veterans is crucial to attaining the goal of effective clinical interventions. If the

set up of the program does not allow for the social worker to thoroughly assess a homeless veteran, develop a treatment plan that caters to his/her individual needs, and provide the means and the support needed to attain the goals and the objectives established, eradicating homelessness is still a dream not a reality.

If innovative ways of serving homeless veterans is the key to making a difference in preventing future homelessness, an overhaul of the current way of providing assistance may be needed. Including implementation of need assessments and serious program evaluation to determine if the measures that are in place are aspects of the program that are truly beneficial or just a band-aide solution to the problem and serves no purpose except to resolve short term crises. Social workers and other advocates will need to be equipped with those resources that create an environment that results in effective social work interventions in the fight against homelessness.

Good clinical interventions and program evaluations can not be implemented at a successful level without the support of the policy makers. If homelessness among veterans is to be effectively addressed, the support of those officials who are responsible for appropriating the funds that sustain these programs are crucial. Additionally, they must understand the effects that failing to provide assistance will have on the society as a whole.

The historical nature of homelessness, in general, is a typical example of how ineffective funding , practices and interventions can affect the outcome of any attempts to decrease this public health and social problem. For unique populations such as veterans, the implications for failing to provide specialized assistance and the means to do so are

only aggravating a problem that has grown bigger than anyone could have anticipated.

These homeless men and women have served their country and deserve to be diligently assisted and provided with effective quality services and attention. The homeless veterans continue to suffer as well as their families, communities and society as a whole.

Recommendations

Studies addressing the culturally and other specific needs of homeless African-American veterans are rare. Therefore, it is recommended that to better serve homeless veterans, more research is needed that compares the plight of this unique homeless population with other groups of veterans who either are formally homeless and/or are vulnerable to becoming homeless. Additionally, research is needed to gather ethnographical data from homeless veterans that could help to explain their susceptibility to becoming homeless in an effort to thoroughly address prevention issues.

Conducting evaluations on those programs that are specifically in place to cater to homeless veterans' needs is warranted and recommended also. Another recommendation is for research into the impact of financial assistance on homeless veterans who are disabled, mentally and/or physically, but are not receiving compensation for unspecified reasons.

Lastly, social workers should become involved in the type of research that will provide information and data specifically targeted for this population to assist with improvements in the facilitation of delivering services.

APPENDIX A

SURVEY QUESTIONNAIRE

An Analysis of Precipitating Factors among Homeless African-American Veterans

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Section I: Demographics:
Place a mark (x) next to the appropriate item. Choose only one answer for each question.

1. Gender: 1) _____ Male 2) _____ Female

2. How old are you? 1)_____ under 21 2)_____ 21-29 3) _____ 30-38 4)_____ 39-47
5)_____ 48-56 6) _____ over 56

3. Ethnicity/Race: 1)_____ African-American 2)_____ Asian 3)_____ Caucasian
4)_____ Hispanic 5)___ Native American

4. Marital Status: 1)_____ Never-married 2)_____ Married 3)_____ Separated
4)_____ Divorced 5)_____ Widowed

5. Educational Background: 1)_____ High School/GED 2) _____ Some College/Vocational
3)_____ College Degree

6. Where I grew up: 1) _____Urban Inner - City 2) _____ Suburb 3) _____ Rural

VA Form 10-1056

Go to page 2 →

APPENDIX A: Survey Questionnaire Continued

Section II: Military Culture:

7.What was your branch of the service? 1)_____ Army 2)_____ Navy

3)_____ Air Force 4)_____ Marines 5)_____ Other (specify)_____

8. What was your military status? 1)_____ Officer 2)_____Enlisted

9. Military Service: 1)_____Drafted 2)____ Volunteered

10. What was your period of service? (check longest one) 1)_____ Pre-WWII (11/18-11/41)

2)_____ WWII (12/41-12/46) 3)_____ Pre-Korean (11/47-6/50) 4)_____ Korean War (7/50-1/55)

5)_____ Between Korean and Vietnam eras 6)_____ Vietnam Era (8/64-4/75)

7) _____ Post-Vietnam (5/75-7/90) 8)_____ Persian Gulf (8/90-)

11. Total length of time served in the military? 1)____ less than 3 years 2)_____3 to 6 years

3)____ 7 to 10 years 4)_____ 11 to 14 years 5)_____15 years and up

12. Are you a Retiree? 1) _____Yes 2) _____ No

13. What was your Military Occupational Specialty? 1)_____ Administrative 2) _____Clerical

3) _____Communications 4) _____ Engineering 5) _____ Food Services 6) _____ Infantry

7) _____ Maintenance 8) _____ Medical 9) _____ Other (Specify)_____

14. Did you ever receive hostile or friendly fire in a combat zone? 1)____ Yes 2) ____ No

Section III: Psychosocial Information:

15. Have you been treated for alcohol? 1)_____ Yes 2)____ No

16. Have you been treated for drugs? 1)_____ Yes 2)____ No

17. Have you been treated for a psychiatric/mental problem?

1)_____ Yes 2)____ No (Specify)_____

Go to page 3 →

APPENDIX A: Survey Questionnaire Continued

18. Are you presently being treated for an ongoing medical condition?

1)____ Yes 2) _____ No Specify_____

19. Do you receive any public financial support? 1) ____ Yes 2) ____ No

20. Do you receive financial support for a service connected psychiatric disorder?

1) ____ Yes 2) ____ No

21. Do you receive financial support for a service connected/other?

1) ____ Yes 2) ____ No

22. Do you receive financial support for a non – service connected pension?

1) ____ Yes 2) ____ No

23. Do you receive financial support for a non- VA disability (SSDI / SSI)?

1) ____ Yes 2) ____ No

Section IV: Homelessness

24. How long have you been homeless? 1)_____ Not currently homeless

2) _____ at least one night but less than one month 3) _____ at least one month but less than 6 months

4)_____ at least 6 months but less than 1year 5)_____ at least 1 year but less than 2 years

6) _____ 2 years and up

24 b. How many times have you been homeless, including this time? _____

24 c. Why are you currently homeless? _____

Go to page 4 →

APPENDIX A: Survey Questionnaire Continued

Section V: Family of Origin

25. I grew up in a stable family 1)____ Yes 2)____ No

26. I grew up in an unstable family 1)____ Yes 2)____ No

27. I was raised by a single parent 1)____ Yes 2)____ No

28. My family of origin received public assistance for financial support

(welfare, food stamps etc). 1)____ Yes 2)____ No

Section VI: Family & Social Support

29. I have a supportive family 1)____ Yes 2)_____ No

30. I have friends who do not use drugs 1)____ Yes 2)_____ No

31. I have family and friends with whom I can share my thoughts and feelings.

1)____ Yes 2)_____ No

Section VII: Individual Resilience

Circle the appropriate number that you agree/disagree with.
Circle only one number for each statement.

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
32. I am able to overcome difficulties or traumatic events quickly and move on with my life.	1	2	3	4
33. I do not allow obstacles to keep me from accomplishing what I want to do.	1	2	3	4
34. I am able to successfully cope with situations that life hands me.	1	2	3	4
35. I bounce back from failures quickly and continue until I am successful.	1	2	3	4

APPENDIX A: Survey Questionnaire Continued

36. I can endure a lot of setbacks and still try to succeed in life.	1	2	3	4

Thank you very much for your cooperation

Irma J. Gibson 06/16//03
Ph.D. Program School of Social Work
Clark Atlanta University, Atlanta, Georgia 30314

VA Form 10-1056

APPENDIX B

SPSS PROGRAM ANALYSIS

```
TITLE 'HOMELESSNESS AMONG AFRICAN AMERICAN VETERANS'.
SUBTITLE 'Irma J Davis-Gibson  CAU School of Social Work'
        'Amos A Ajo, PhD - Director of PhD Program'
     'Committee Members'
     'Richard Lyle, PhD - Committee Chair'
     'Craig Burnette, EdD'
     'Robert W Waymer, PhD'.

DATA LIST FIXED/
ID         1-3
GENDER     4
AGEGRP     5
ETHNIC     6
MARITAL    7
EDUC       8
GREWUP     9
BRANCH     10
RANK       11
SERVICE    12
PERIOD     13
TIME       14
RETIRE     15
MOS        16
COMBAT     17
ALCOHOL    18
DRUGS      19
MENTAL     20
MEDCOND    21
PUBLIC     22
PSYCON     23
OTHCON     24
NONCON     25
NONVA      26
HOMELES    27
```

APPENDIX B: SPSS Program Analysis Continued

```
STABLE    28
UNSTAB    29
SINGPA    30
ASSIST    31
SUPPORT   32
NODRUGS   33
FAMILY    34
TRAUMA    35
OBSTACL   36
COPE 37
FAILURE   38
SETBACK   39.


VARIABLE LABELS
ID         'Case Number'
GENDER     'Q1 Gender'
AGEGRP     'Q2 How old are you'
ETHNIC     'Q3 Ethnicity'
MARITAL    'Q4 Marital Status'
EDUC       'Q5 Educational Background'
GREWUP     'Q6 Where I grew up'
BRANCH     'Q7 What was you branch of the service'
RANK       'Q8 What was your military status'
SERVICE    'Q9 Military Service'
PERIOD     'Q10 What was your longest period of service'
TIME       'Q11 Total length of time served in the military'
RETIRE     'Q12 Are you a Retiree'
MOS        'Q13 What was your Military Occupational
           Specialty'
COMBAT     'Q14 Did you ever receive hostile or friendly
           fire in a combat zone'
ALCOHOL    'Q15 Have you been treated for alcohol'
DRUGS      'Q16 Have you been treated for drugs'
MENTAL     'Q17 Have you been treated for a
           psychiatric/mental problem'
MEDCOND    'Q18 Are you presently being treated for an
           ongoing medical condition'
PUBLIC     'Q19 Do you receive any public financial support'
PSYCON     'Q20 Do you receive financial support for a
           service connected' psychiatric disorder'
```

APPENDIX B: SPSS Program Analysis Continued

```
OTHCON     'Q21 Do you receive financial support for a
           service connected/other'
NONCON     'Q22 Do you receive financial support for a non-
           service connected pension'
NONVA      'Q23 Do you receive financial support for a non-
           VA disability'
HOMELES    'Q24 How long have you been homeless'
STABLE     'Q25 I grew up a stable family'
UNSTAB     'Q26 I grew up in an unstable family'
SINGPA     'Q27 I was raised by a single parent'
ASSIST     'Q28 My family of origin received public
           assistance for financial support'
SUPPORT    'Q29 I have a supportive family'
NODRUGS    'Q30 I have friends who do not use drugs'
FAMILY     'Q31 I have family and friends with whom I can
           share my thoughts' and feelings'
TRAUMA     'Q32 I am able to overcome difficulties or
           traumatic events' quickly and move on with my
           life'
 OBSTACL   'Q33 I do not allow obstacles to keep me from
           accomplishing what' I want to do'
 COPE      'Q34 I am able to successfully cope with
           situations that life hands me'
 FAILURE   'Q35 I bounce back from failures quickly and
           continue until I am' successful'
 SETBACK   'Q36 I can endure a lot of setbacks and still try
           to succeed in life'.

VALUE LABELS
 GENDER
   1 'Male'
   2 'Female'/
AGEGRP
   1 'Under 21'
   2 '21-29'
   3 '30-38'
   4 '39-47'
   5 '48-56'
   6 'over 56'/
ETHNIC
   1 'African-American'
```

APPENDIX B: SPSS Program Analysis Continued

```
  2 'Asian'
  3 'Caucasian'
  4 'Hispanic'
  5 'Native American'/
MARITAL
  1 'Never Married'
  2 'Married'
  3 'Separated'
  4 'Divorced'
  5 'Widowed'/
EDUC
  1 'High School GED'
  2 'Some College Voc'
  3 'College Grad'/
GREWUP
  1 'Urban Inner-City'
  2 'Suburb'
  3 'Rural'/
BRANCH
  1 'Army'
  2 'Navy'
  3 'Air Force'
  4 'Marines'
  5 'Other'/
RANK
  1 'Officer'
  2 'Volunteered'/
SERVICE
  1 'Drafted'
  2 'Volunteered'/
PERIOD
  1 'Pre WWII'
  2 'WWII'
  3 'Pre Korean'
  4 'Korean War'
  5 'Between K and Vietnam'
  6 'Vietnam Era'
  7 'Post Vietnam'
  8 'Persian Gulf'/
```

APPENDIX B: SPSS Program Analysis Continued

```
TIME
  1 'Under 3 yrs'
  2 '3-6 yrs'
  3 '7-10 yrs'
  4 '11-14 yrs'
  5 '15yrs up'/
RETIRE
  1 'Yes'
  2 'No'/
MOS
  1 'Administration'
  2 'Clerical'
  3 'Communications'
  4 'Engineering'
  5 'Food Services'
  6 'Infantry'
  7 'Maintenance'
  8 'Medical'
  9 'Other'/
COMBAT
  1 'Yes'
  2 'No'/
ALCOHOL
  1 'Yes'
  2 'No'/
DRUGS
  1 'Yes'
  2 'No'/
MENTAL
  1 'Yes'
  2 'No'/
MEDCOND
  1 'Yes'
  2 'No'/
PUBLIC
  1 'Yes'
  2 'No'/
PSYCON
  1 'Yes'
  2 'No'/
```

APPENDIX B: SPSS Program Analysis Continued

```
OTHCON
  1 'Yes'
  2 'No'/
NONCON
  1 'Yes'
  2 'No'/
NONVA
  1 'Yes'
  2 'No'/
HOMELES
  1 Not currently homeless'
  2 '1 night-less 1 month'
  3 '1 month -less 6 mons'
  4 '6 mons    - less 1 yr'
  5 '1 yr - less 2 yrs'
  6 '2 yrs and up'/
STABLE
  1 'Yes'
  2 'No'/
UNSTAB
  1 'Yes'
  2 'No'/
SINGPA
  1 'Yes'
  2 'No'/
ASSIST
  1 'Yes'
  2 'No'/
SUPPORT
  1 'Yes'
  2 'No'/
NODRUGS
  1 'Yes'
  2 'No'/
FAMILY
  1 'Yes'
  2 'No'/
```

APPENDIX B: SPSS Program Analysis Continued

```
TRAUMA
  1 'Strongly Disagree'
  2 'Disagree'
  3 'Agree'
  4 'Strongly Agree'/
OBSTACL
  1 'Strongly Disagree'
  2 'Disagree'
  3 'Agree'
  4 'Strongly Agree'/
COPE
  1 'Strongly Disagree'
  2 'Disagree'
  3 'Agree'
  4 'Strongly Agree'/
FAILURE
  1 'Strongly Disagree'
  2 'Disagree'
  3 'Agree'
  4 'Strongly Agree'/
SETBACK
  1 'Strongly Disagree'
  2 'Disagree'
  3 'Agree'
  4 'Strongly Agree'/.

MISSING VALUES
 GENDER AGEGRP ETHNIC MARITAL EDUC GREWUP BRANCH RANK
SERVICE PERIOD TIME RETIRE MOS COMBAT ALCOHOL DRUGS MENTAL
MEDCOND PUBLIC PSYCON OTHCON NONCON NONVA HOMELES STABLE
UNSTAB SINGPA ASSIST SUPPORT  NODRUGS FAMILY TRAUMA OBSTACL
COPE FAILURE SETBACK (0).

BEGIN DATA
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APPENDIX B: SPSS Program Analysis Continued

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APPENDIX B: SPSS Program Analysis Continued

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APPENDIX B: SPSS Program Analysis Continued

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APPENDIX C

EMORY UNIVERSITY IRB APPROVAL LETTER

EMORY UNIVERSITY

Institutional Review Board

Irma Gibson MHSL
VA - Veterans Administration
1670 Clairmont Rd.
Decatur, Ga 30033

RE: **NOTIFICATION OF PROTOCOL APPROVAL**
PI: Irma Gibson MHSL
IRB ID: **588-2003**
TITLE: A comparative Analysis of Homelessness Among Never Married and Married African American Veterans
DATE: July 16, 2003

The research proposal referenced above was reviewed and APPROVED under the Expedited review process. This approval is valid from 7/16/2003 until 7/15/2004. Thereafter, continued approval is contingent upon the submission of a renewal form that must be reviewed and approved by the IRB prior to the expiration date of this study.

Any serious adverse events or issues resulting from this study should be reported immediately to the IRB and to any sponsoring agency (if any). Amendments to protocols and/or revisions to informed consent forms/process must have approval of the IRB before implemented.

All inquires and correspondence concerning this protocol must include the IRB number and the name of the Principal Investigator.

If you have any questions or concerns, please contact the IRB office at 404-727-5646 or at email address irb@emory.edu. Our web address is http://www.emory.edu/IRB. Thank you.

Sincerely,

Karen A. Hegtvedt, Ph.D.
Chair
Social, Humanist, Behavioral IRB

KAH/mjc

Emory University
4th Floor, South Wing
1256 Briarcliff Road
Atlanta, Georgia 30306

Tel 404.727.5646
Fax 404.727.3358
Email IRB@emory.edu

APPENDIX D

DVA R&D COMMITTEE APPROVAL LETTER

Department of Veterans Affairs

Memorandum

Date August 7, 2003

From Chairperson, Research and Development Committee

Subj Research Proposal Final Approval - 2003-060248

To Irma J. Gibson, MSW (122)

1. On August 7, 2003, the Research and Development Committee gave **final approval** to your study, entitled *A Comparative Analysis of Homelessness among Never Married and Married African American Veterans*. The study was approved by the Institutional Review Board on July 16, 2003.

2. Approval carries with it the understanding that:

   a. You will make no modification to this study without prior approval by the Institutional Review Board and the R&D Committee, and all advertisements and supplemental materials will be submitted for approval prior to their use.

   b. You will inform the Institutional Review Board of any adverse events that occur.

   c. You will submit documents for continuation approval at least once annually or more often if requested.

   d. If a research consent form is required, you will place a signed form in the patient's hospital medical chart, will flag the chart and will enter a progress note stating the patient is entered in the study (study title) and will include the name and phone number of the investigator to contact for further information.

3. Any material submitted for publication that is generated from this study must be submitted for review by the R&D Committee. You must also acknowledge the VA on any published materials generated from this study. For further clarification, the policy is located at: http://www.va.gov/publ/direc/health/handbook/1200.19hk.pdf

4. Thank you for your cooperation in helping us adhere to the rules and regulations of the Research and Development Office of the Department of Veterans Affairs in protecting the rights and welfare of human subjects involved in medical research.

David M. Guidot, MD

APPENDIX E

CLARK ATLANTA UNIVERSITY IRB APPROVAL LETTER

CLARK ATLANTA UNIVERSITY

Institutional Review Board

October 1, 2003

Irma J. Gibson
VA Medical Center #122
1670 Clairmont Road
Decatur, GA 30033

RE: A Comparative Analysis of Homeless-ness Among Never Married and Married African-American Veterans

Principal Investigator: Irma J. Gibson

Human Subjects Code Number: HR2003-07-107-3

Dear Ms. Brinson:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed and approved the referenced study as revised, protocol date September 30, 2003.

Your Study Approval Number is **HR2003-07-107-3/A**

Approval for the study begins on October 8, 2003 and is effective till September 30, 2004 after which time a continuation approval must be sought.

If you have any questions, please contact the IRB office at *(404) 880-6979.*

Sincerely:

Paul I. Musey, Ph.D.
Chair
IRB: Human Subjects Committee

cc. Dr. Georgianna D. Bolden
Grants and Contracts Administration

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